VIRGINIA HEALTH CARE FOUNDATION

PROPOSAL COVER SHEET for MOM Projects

Name of Applicant Organization: _____

Amount of Request to VHCF (*Year 1*): $_____ Total Project Cost (*Year 1*): $_____

Month and Year Proposed for MOM project: _____

Applicant Information:

Name of Executive Director of Applicant Organization: _____

Telephone: _____ E-mail Address: _____

Address: _____

City, State, Zip Code: _____

Fax: _____ Web Address: _____

Check One: ☐ 501(c)3 ☐ Public Entity ☐ Other

Is there an organization other than the applicant acting as a fiscal agent for this project?

☐ Yes ☐ No

<u>If yes, please indicate the following</u>:

Name of Fiscal Agent Organization: _____

Contact Person: _____ Telephone: _____

Name of Project Director (*If Different from Executive Director*): _____

Project Director Title: _____

Telephone: _____ E-mail Address: _____