Grant Application Form

Health Center Information

Name of Health Center:_____

Address of Health Center:_____

Applicant Information

Name of Applicant: _____

Position of Applicant: _____

E-mail of Applicant: _____

Phone Number of Applicant: _____

Funding Request:

Summary - Add an attached description of your funding request.

Please use 150 words or less.

Amount Requested: _____

Maximum request is $5,000

Other Sources of Revenue for This Project

List in attachment

Submit to:

Healthy Houston Foundation
1770 Saint James Place, Suite 250
Houston, TX 77056

Applicant Signature: **Date:**

_____ _____