Charitable Grant Request Form *

Organization Name: ____

Address: ____

____

Contact Name and Title: ____

Phone: ______________________ Fax: ______________________

Email: ______________________ Website: ______________________

Tax ID Number: ______________ (First 2 pages and signature page of Form 990 must be attached to all requests)

Is the organization:

A 501(c)3 non-profit? ___Yes ___No (if no, we cannot consider your request)
A local chapter of a national charity? ___Yes ___No

Does your charity provide mental health and/or suicide prevention services? ____ Yes ____No

Please give a brief summary of:

(a) the mission of your organization:

(b) the mental health/suicide prevention activities that your organization focuses on:

Please describe how this grant will specifically be used and who will benefit from it (a short written report will also be required within 9 months of all donations):

Please list any other organizations that you have applied to for support or who are currently supporting this project/program:

Age group served (youth, seniors, etc.): ____

Please note any specific geographic areas, racial or ethnic or cultural groups that will be served by your project:

Amount of total budget for this program/project: __________ Amount of request: ___________

If a donation is approved, check should be made payable to and mailed to:

____

____

Signature: ____ Date: _____________________

*This request form shall serve as a request only and in no way is a guarantee or a promise of a receipt of charitable funds from the Connecticut State Medical Society Charitable Trust. You must complete this form. Additional appendices are not necessary and may slow down the evaluation process.

Please send request (and Form 990 pages) to:

Connecticut State Medical Society Charitable Trust
127 Washington Ave.
East Building, Third Floor
North Haven, CT 06473

For CSMS Use Only

Received	Verified	Staff Review	Committee Review	Approved	Paid