

**SAINT FRANCIS COMMUNITY HEALTH
CARE, INC**
Community Request for Proposal Cover Sheet

Name of organization:

Address: _____

Program Director:

Name: _____

Title: _____

Telephone: _____

E-mail: _____

Other Program Contact:

Name: _____

Title: _____

Telephone: _____

E-mail: _____

Title of Program:

Total program budget: \$ _____

Amount requested

in this proposal: \$ _____

Organization CEO or executive director
(if different from program director):

Name: _____

Title: _____

Telephone: _____

E-mail: _____

Fiscal Officer (if applicable):

Name: _____

Title: _____

Telephone: _____

E-mail: _____

Geographic area(s) served by this program:

Brief summary of proposed program:

Collaborative partners (if applicable):

Signature of program director(s)

_____ Date: _____

Signature of fiscal officer:

_____ Date: _____
