ORLANDO HEALTH®

Orlando Health Community Grant Program

Letter of Intent Form

The Letter of Intent must be no more than the given space below, which is equivalent to two pages.
Please send to CommunityBenefit@OrlandoHealth.com upon completion.

Applicant Information

Name of Organization: ______________________________

Applicant Name: ____________ ____________ ____________
First *Last* *Job Title*

Address: ______________________________ ____________
Street Address *Apartment/Unit #*

____
Street Address 2

______________________________ ____________ ____________
City *State* *ZIP Code*

Phone: ____________ Email: ____________

Federal Tax ID: ____________

Preliminary/proposed budget amount
(suggested range of $500 - $50,000) **$** ____________

Organization Website: ____________

Title of Proposed Project: ____________

Will your project create change in one or more of the following areas?				
Access to Care	YES ☐	NO ☐	If yes, how?	
Health Equity	YES ☐	NO ☐	If yes, how?	
Food Security & Nutrition	YES ☐	NO ☐	If yes, how?	

Need Identified

Please identify the need for this project and the relevance to an area identified in the 2019 Community Health Needs Assessment (CHNA) in the space provided below.

Target Population

Please identify the target population and potential number of people impacted through the proposed project in the space provided below.

Measureable Outcomes

Please provide how outcomes will be measured for the proposed project in the space provided below.

Sustainability

Please provide plans for sustainability beyond one year of funding in the space provided below.