



OUR LADY OF BELLEFONTE HOSPITAL
Bon Secours Health System

***Our Lady of Bellefonte Hospital Foundation
Community Support Fund Grant Application***

Date _____

Organization Name and Address

Contact(s) and title(s)

Phone number(s) including area code

Fax number(s) including area code

E-mail address(s)

Brief history/purpose of the organization

Brief summary of project/request

Duration of project/request

Amount requested

Other sources of donations(please list)

Date funds needed

Project budget (if applicable)

How and when will the success/completion of the project be measured (if applicable)

Geographic area(s) most affected

Please return the completed application to:

***Our Lady of Bellefonte Hospital Foundaion
1000 St. Christopher Drive
Ashland, KY 41101***

If funding is approved, a use of funds report will be required to be completed and returned to OLBH within 1 (one) year of receipt of funding. The reporting information sheet will be attached to any approved grant award.