Marshall Health Network, Inc.
formerly Mountain Health Network
Donation/Community Building Activity

Your Organization

Organization name _____
Purpose/Mission _____
501(c)3 status _____
EIN (Tax ID) _____ Website _____
Email _____ Phone number _____
Address _____

Request

Is this for a donation, support for a community event or both? _____
Donation/event support amount _____
Please explain how the funds will be used _____

_____

Date funds needed _____

Event Details

Event name _____ Type of event _____ Date _____
Location _____
Description _____
Fundraising goal _____ Website _____
How many years has the event run? _____
Expected attendance _____
Describe your attendees/audience _____
Sponsorship guide _____
List of Board members _____

_____

Contact Information

Your name _____
Email _____
Phone number _____
What is your role within the organization? _____
Mailing address _____

Additional information – please include as separate attachment. All areas of this form must be completed in order to be considered. Email all information to communityhealthneedsassessment@mhnetwork.org.