VIRGINIA HEALTH CARE FOUNDATION

6806 Paragon Place, Suite 250 • Richmond, VA 23220 • **www.vhcf.org**
Phone: (804) 828-5804 • Fax: (804) 828-4370 • email: info@vhcf.org

CONCEPT PAPER COVER SHEET

Name of Applicant Organization: _____

Project Title: _____

Amount of Request to VHCF: $_____ Total Project Cost: $_____

VHCF's Contribution Towards Total Project Costs (%): _____%

Please briefly describe how VHCF funds will be used *(Ex: Portion of salary and benefits for a full-time nurse practitioner):*

_____

_____

_____

Area to be Served: _____

Applicant Information:

Name and Title of Executive of Applicant Organization: _____

_____

Telephone: _____ Mobile Phone: _____

E-mail Address: _____

Address: _____

City, State, Zip Code: _____

Fax: _____ Web Address: _____

Check One: ☐ 501(c)3 ☐ Public Entity ☐ Other

Is there an organization other than the applicant acting as a fiscal agent for this project?

☐ Yes ☐ No

If yes, please indicate the following:

Name of Fiscal Agent Organization: _____

Contact Person: _____ E-mail Address: _____

Telephone: _____ Mobile Phone: _____

Name of Project Director (*If Different from Executive Director*): _____

Project Director Title: _____

E-mail Address: _____

Telephone: _____ Mobile Phone: _____

This form can be downloaded from VHCF's website www.vhcf.org.
If you have questions, please contact a Program Officer at (804) 828-5804.