

Community Contribution Request Form

Phone:	Organization:		
City, State, Zip:		Phone:	
Event / Program Details: Name of Event / Program:			
Name of Event / Program: Date: Description: How would you describe your event or organization? Community / Civic Activity □Education Related □Health Organization □Non-Profit Organization □Youth Focused In which area will this program help to improve the health of the people of Siouxland? □Patient Care Coordination □ Mental Health Services Enhancement □Elder Care Services □Health and Fitness □ Maternal/Prenatal Care □Other: □Other: What are the benefits to the community if this request is approved? Target audience and number of people impacted by program: □Other:	Address:		
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Patient Care Coordination	•		
Target audience and number of people impacted by program: How is the event promoted? Levels of giving/sponsorship available and forms of recognition at each level: If request is not awarded this quarter, do you want it considered next quarter?	□Patient Care Coordination □ Mental Health Services	Enhancement	
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Monetary Donation Request: Requested dollar amount:	Levels of giving/sponsorship available and forms of r	ecognition at each level:	
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