



A Component Fund within the
Community Foundation of
Warren County's Corporate Division

THE DEFREES FAMILY MEMORIAL FUND

PO Box 691 • Warren, PA 16365
Phone (814) 726-9553
Fax (814) 726-7099
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GRANT APPLICATION

DATE RECEIVED BY CFWC

Name of Organization _____ Date Founded _____

Address (street) _____ City/State/Zip _____

Date of Application _____ Amt Requested _____

Name/Title _____ Phone _____

Status 501 (c) 3 Include IRS Determination Letter

509 (a) ____ Enter status classification: 1, 2, or 3 (found on IRS Determination Letter)

Enter EIN/Tax ID _____ Did you file form 990 last year? Yes No
(If yes, please attach a copy of page 1)

Have you previously requested Defrees Family Memorial Funds? Yes No

If YES, please indicate for most recent request: When? _____ How Much? _____

CURRENT YEAR

PRIOR YEAR

Total Organization Revenue _____

Primary Sources of Revenue _____

Start Date of Fiscal Year _____ Financial Report for last fiscal year attached

Primary Sources of Income (grants, fees, etc.) _____

Total Endowment _____ Total Reserves _____ Total Debt _____

Total Cost of Project/Program _____ Amt. Allocated from your Organization _____

Other Funders for this specific project	Amount	Indicate whether Committed (C), Pending (P), or Not Yet (NY)
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1. _____

2. _____

3. _____

4. _____

5. _____

of Board Members _____ # of Staff _____ # of Volunteers _____

GRANT APPLICATION

Please provide a brief description of your organization, focusing primarily on the project for which you are seeking funding. Your summary should include the project's objectives and goals, implementation methods, who the project will serve, a plan for self-evaluation, and future funding plans. Your summary should not exceed the space below; please type or provide an attached printout.

Organization _____ Applicant _____

Signature _____ Date _____