Health Care Funding Request Form

Project Name: _____

Requesting Organization: _____

Primary Contact: _____

Contact Information: _____

Project Description:

_____

_____

Date of Delegation to Council (if applicable): _____

Requested Amount: _____

Date Funding Required by: _____

Is the funding requested as a one-time payment or multiyear commitment?

_____

_____

Eligibility:

Is this project for Capital or Equipment?	**Y**	**N**
Has Provincial Approval of the Project been received?	**Y**	**N**
Does the project Create service improvements and respond to an identified need in the community.	**Y**	**N**
Is the facility located in Bruce County, or do Bruce County residents make up at least 20% of patients served?	**Y**	**N**
Does your project align with the service delivery plans and initiatives of the County?	**Y**	**N**

Has the Requesting Organization submitted funding requests or plan to submit funding requests to other municipalities? If so please indicate which municipalities:

_____

_____

Thank you for your submission. The County will provide confirmation of the results of the request and review once the annual budget has been approved.