



Community Health Sponsorship Request Form

Organization Information

Organization Name: _____

Contact Person: _____

Title: _____

Address: _____

Phone: _____ **Email:** _____

Website: _____

Tax ID (if applicable): _____

Sponsorship Request

Event/Program Name: _____

Date(s): _____

Location: _____

Amount Requested: \$ _____

Total Event/Program Budget: \$ _____

Alignment with District Priorities (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Expands access to healthcare | <input type="checkbox"/> Improves health outcomes |
| <input type="checkbox"/> Addresses food insecurity | <input type="checkbox"/> Promotes healthy eating |
| <input type="checkbox"/> Strengthens the healthcare workforce | <input type="checkbox"/> Supports overall community wellness |



Brief Description (250 words or less)

Describe the event, program, or organization and how the sponsorship will benefit residents within the Bloss Memorial Healthcare District service area.

Community Impact

Estimated number of people served or reached: _____

Primary population served:

- General Community Seniors Children/Youth Rural Residents
- Low-Income Individuals/Families Diverse/Underserved Populations
- Other: _____

Sponsorship Recognition

How will Bloss Memorial Healthcare District be recognized?

- Event Sponsor Logo on Marketing Materials Social Media Recognition
- Booth/Table Opportunity Speaking Opportunity Other: _____

Certification

I certify that the information provided is accurate and that any sponsorship funds awarded will be used for the purposes described above.

Authorized Representative Name: _____

Signature: _____ **Date:** _____