The Mary McClellan Foundation, Inc.
P.O. Box 90
Greenwich, NY 12834

2025 Grant Application

APPLICATION DEADLINE: Monday, September 8, 2025

Applications may be submitted on paper (must be typed or printed in ink) or electronic format.
No applications will be accepted after the deadline.

Part I: General Information

1. Applicant Name: _____

2. Mailing Address: _____

3. Applicant's Prime Contact Person:

(a) Name:_____

(b) Title: _____

(c) Telephone Number: _____

(d) Fax Number: _____

(e) Email Address: _____

4. Organization Information:

(a) Federal ID#_____ (b) NYS Charities Registration No.: _____

(c) Date of Not-for-Profit Incorporation_____ (d) Fiscal Year End Date_____

(e) Number of Board Members (Attach List)_____ (f) # of Times Board Meets Annually_____

(g) Geographic Area/Township(s) Served: _____

(h) Proof of eligibility (list and attach): _____

5. Outline Your Organization's Mission; Provide a Brief History of the Services; and Describe Current Programs/Services that Your Organization Offers:

Part II: Program Information (*if applicant is applying for more than one grant, please complete a separate Part II and Part III A. for each program for which you are seeking funding and prioritize grants sought*)

1. Name of the Program for Which Organization Seeks MMF Funding: _____

_____

2. (a) Total Amount Requested from MMF: _____ (b) Priority for Funding: circle: 1st 2nd or 3rd

If applying for a multi-year grant, please complete the following:

(c) 1st Annual Installment _____ 2nd Annual Installment _____

3rd Annual Installment _____ 4th Annual Installment _____

5th Annual Installment _____

3. Describe the Need, Health Problem or Service Gap that the Program Seeks to Address in Southern Washington County and/or Hoosick Falls, particularly since the closure of the hospital:

Provide concrete data to support. (If the space below is not sufficient you may use an additional 8/12 x 11' page of paper using a font no smaller than 12).

4. Describe in detail the program for which funding is sought. Offer details particular to your grant application such as specific health services to be offered, equipment to be purchased, types of personnel to be hired or trained, publications to be developed, communities and populations to be targeted. (If the space below is not sufficient you may use an additional 8/12 x 11' page of paper using a font no smaller than 12). If a specific specialized medical personnel or piece of medical equiment is to be funded with MMF support attached position description or brochure about medical equipment. *Please note: requests for non-medical furniture will not be considered.* Please be very clear how MMF funds will be spent.

5. **Describe the impact or how this program will benefit the community? (Note: Indicate demographics, geographic reach and how many people it is anticipated will be served. List ways in which the organization will track or measure the impact in Southern Washington County and Hoosick Falls.)**

Part III. Financial Information

A. Project Budget

Please fill out the Project Budget Below:

	Expenses
Personnel	**$**
(a)	
(b)	
Medical Equipment	
Medical Facility Upgrades	
Service Delivery Programs	
Outreach Programs	
GRAND TOTAL	**$**
	Revenue
Fees Generated	
Other Cash Donations Raised	
Other Cash Donations to Be Raised	
In-Kind Services	
Specific Funds Requested From MMF	
GRAND TOTAL	**$**

If necessary, in the space provided below provide notes clarifying budget figures.

For multi-year grant applications, include a separate budget for each year.

B. Financial Information about Not-For-Profit

Date of Last Filing with the IRS (if applicable) _____
Date of Last Filing with the Charities Bureau (if applicable) _____

The figures below are taken from the attached financial report for fiscal year ending _____

****Round off to the nearest dollar****

CASH ON HAND, Beginning of Fiscal Year		**$**
REVENUE for the year	**$**	
EXPENSES for the year	**$**	
SURPLUS (DEFICIT) for the year		**$**

Attach a complete copy of the most recently filed IRS Form 990 or 990EZ along with the Annual Filing for Charitable Organizations (CHAR500) submitted to the NYS Department of Law, Charities Bureau.

CERTIFICATION AND STATEMENT OF ASSURANCES

The Applicant certifies, represents and warrants to The Mary McClellan Foundation, Inc.:

1. That the information, statements and representations contained in this Application, and in all attachments and supporting material is, to the best of the applicant's belief, true, accurate and complete;
2. That the applicant accepts in advance any grant awarded to it, agreeing:
    a) That any funds received as a result of the application will be expended under the terms and conditions of the Grant; and
    b) To such other restrictions, conditions or changes as The Mary McClellan Foundation may impose, unless the applicant objects within fifteen (15) days of the mailing of the grant award letter.
3. That the person whose signature appears below is duly authorized to submit this application and to sign this Certification and Statement of Assurances and commit the applicant to the terms, conditions and provisions herein contained.
4. That this Certification and Statement of Assurances is a material representation of fact upon which reliance will be placed by The Mary McClellan Foundation. If it is later determined that the applicant knowingly provided inaccurate, false, incomplete or misleading information in this application, or rendered an erroneous Certification and Statement of Assurances, in addition to other legal remedies available to it, The Mary McClellan Foundation may terminate any award which has been made to the applicant and require the immediate repayment of all grant funds which have been disbursed.
5. That this Certification and Statement of Assurances shall be legally binding upon the applicant and any persons or organizations who, by subsequent transfer or assignment, acquire an interest in the grant

_____
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE/OFFICIAL

_____
SIGNATURE OF AUTHORIZED REPRESENTATIVE/OFFICIAL

_____
DATE