



## DELTA DENTAL OF ILLINOIS COMMUNITY BENEFIT GRANT APPLICATION

### ORGANIZATION INFORMATION

Date of Request:		
Legal Name of Organization :		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Executive Director:		
Authorized Contact Person(s) and Title(s)		
Mission Of Organization:		
Is your organization an IRS 501(c)(3) or 501(c)(4) not-for-profit? _____ Yes _____ No <i>If Yes, please enclose a copy of the 501(c)(3) or 501(c)(4) letter your organization received from the IRS. Please also include the most recent financial statement, an income statement and a balance sheet.</i>		
<i>If No, please explain:</i>		

### REQUEST INFORMATION

Delta Dental of Illinois provides funding and goods-in-kind to support five oral health care targets. Please indicate the area(s) addressed by your program or organization.
_____ Raising awareness of the importance of oral health.
_____ Improving oral health knowledge.
_____ Making oral health care more accessible to the underserved in Illinois
_____ Making oral health care more affordable to the underserved in Illinois.
_____ Improving education for oral health professionals.
Funding Request Amount:
Goods-in-kind Request: Toothbrushes (quantity) _____ Oral Health Education Brochures (quantity) _____ Other (specify) _____
Total Program Budget:
Total Organizational Budget (current year)

**PROGRAM INFORMATION**

Delta Dental of Illinois' mission is to provide exceptional services to our stakeholders and improve the oral health of the communities we serve.

How will funding this grant request improve oral health in Illinois? (State briefly. Include any participant qualifications for the program. Additional background may be attached.)

Please describe the program goals and outcome objectives. Include information on how you will measure the impact of your program.

Target Population:

Number of People Served by Your Program:

Please indicate the location(s) of the communities served by the program.

Has your organization received funding from Delta Dental of Illinois previously? \_\_\_\_\_ Yes \_\_\_\_\_ No

*If Yes, have you shared the results of that program with Delta Dental of Illinois?* \_\_\_\_\_ Yes \_\_\_\_\_ No

I certify that we are eligible for funding based on the application guidelines.

Signature: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

Delta Dental of Illinois may visit your site as part of the evaluation process.

Interim and/or Final Reports will be required.

You may attach additional information if you wish, along with this application to:

**Delta Dental of Illinois**  
**Director of Public Responsibility**  
**801 Ogden Avenue**  
**Lisle, Illinois 60532**