



American Academy of Family Physicians Foundation

## Emergency Relief Grant Application

### Application

Date: Enter

### Eligibility check list

- Services are provided at no cost (100% free) to all patients  Yes  No
- Applying Family Physician Champion is a member of the AAFP.  Yes  No
- Clinic is non-denominational and open to all members of the population and not a specific disease state.  Yes  No

**If you answer “No” to any of these statements, you are NOT eligible to apply.**

## 1. CONTACT INFORMATION

### a. Clinic

Name: Enter

Address (Include City, State and Zip Code): Enter

Telephone #: Enter

Email: Enter

Clinic is a Volunteers in Medicine America Clinic:  Yes  No

### b. Primary Contact

Name: Enter

Title: Enter

Telephone #: Enter

Email: Enter

### c. Family Physician (FP) Champion

Name: Enter

AAFP Membership ID #: Enter

Cell (or best contact #): Enter

Email: Enter

Is the FP Champion:

- The medical director of the clinic?  Yes  No
- The board president of the organization?  Yes  No
- An active volunteer providing medical services?  Yes  No

Please describe or provide examples of the FP Champion's leadership role and involvement in the clinic.

**2. CLINIC OVERVIEW** (Please provide brief descriptions for each section below. Support your descriptions by including in the appendix documentation such as an organizational chart, list of board members and their affiliation, etc. **(Do not state "see Appendix")**).

a. **Geographic area(s) (Refer to guidelines):**

b. **Organizational/governing structure:**

c. **Partnerships/collaborations:**

Check what partnerships/collaborations you have or in the process of forming:

- Community Organizations  Hospitals  Residency Programs  Medical Schools  AAFP Chapters/Chapter Foundations

Please describe the relationship for each checked:

d. **Family Medicine residents, medical students, active or retired family physicians are involved as volunteers.**  Yes  No

If yes, estimate the number of volunteers per month:

**Medical Students:**  **Residents:**  **Active FP(s):**  **Retired FP(s):**

Please describe how each are involved:

**3. BUDGET DETAIL** (Please note: This grant is intended to be used to purchase durable and non-durable equipment and supplies and necessary operational expenses.

Items		Estimated Cost*	
<b>1</b>	<b>Durable items:</b> (e.g. Items for the exam room, instruments & equipment, laboratory equipment, software/equipment for EHR etc.)		
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
		<b>Sub-total</b>	Enter
<b>2</b>	<b>Non-durable items:</b> (e.g. PPE, medications, accu check strips, lancets, speculums, gloves, disposable probe covers etc.)		
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
	Enter	Enter	
		<b>Sub-total</b>	Enter
<b>6</b>	<b>Operational expenses</b>		
	Enter	Enter	
	Enter	Enter	
		<b>Sub-total</b>	Enter
		<b>TOTAL AMOUNT REQUESTED</b>	Enter

**Budget Description:** How will each of the items requested be used to enhance care and benefit the patients in your service area during the COVID-19 pandemic? Enter

## 5. Applicant Agreement

In the event a grant is awarded, the applicant on behalf of the clinic agrees to adhere to all award conditions specified by the AAFP Foundation in the accompanying guidelines.

Enter

\_\_\_\_\_  
**Print Name of Family Physician  
Champion**

Enter

\_\_\_\_\_  
**Signature of Family Physician Champion**

Enter

\_\_\_\_\_  
**Clinic Name**

Enter

\_\_\_\_\_  
**Date**

**The application must be completed by computer and sent electronically to Sharon Hunt at [shunt@aafp.org](mailto:shunt@aafp.org).**