

LOS MEDANOS COMMUNITY HEALTHCARE DISTRICT
HEALTH SERVICE GRANTS – 2010 INTERIM GRANTS CYCLE

FINAL REPORT

Organization Name: _____

Address: _____

Contact Persons: _____

Program Description and Population Served:

Amount of Grant by LMCHD: _____

Final budget and expense report. Please indicate expected disposition of any unspent funds.

Starting Point \$ _____

Expenses: _____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

(If necessary, attach second page)

Remaining Budget (unspent funds): \$ _____

Project Goals and Outcomes to

Date: _____

Community Partners/Additional Support:

How has LMCHD been acknowledged in the use of grant funds?

Additional Comments:
