



THE BALD FACED TRUTH FOUNDATION

P.O. Box 69601 Portland, Oregon 97239 www.baldfacedtruth.org

APPLICATION FOR GRANT (Please complete one application per child)

Date: _____

Referral Source: _____ Name of Recipient: _____

Agency: _____ Age: _____ (must be between 6-18)

Address: _____

Contact Person: _____ Phone: _____ Email: _____

REQUEST: (Please include how long the child will be involved in the activity) _____

Name of Provider (organization or individual providing referral): _____

Phone: _____ Email: _____

Tell us about this child's background. Include any information that would be helpful to us in evaluating whether or not we should grant this request (information about the child's family, the financial circumstances, the level of the child's motivation, etc.) :

How do you feel participation in this activity will make a positive and meaningful impact in this child's life? _____

What other agencies have been contacted to request financial (or other) support for this child? _____

Who do you plan to contact in order for the child to continue participating in this activity?

Make Check to: _____

Amount: _____ Due Date: _____

Signature _____

Mail or Email application to BFT Foundation, P.O. Box 69601, Portland, Oregon 97239 info@baldfacedtruth.org

For Office Use Only:

application rejected: application accepted

Referral No.: _____
Referral Date: _____
Date of Follow-up: _____

Reason rejected:
