



Live Well. Health Matters.

MICRO-ENRICHMENT GRANT APPLICATION

A completed application form must be submitted for each request for a Micro-Enrichment Grant (MEG).

Name of Group or Individual: _____

Address: _____

Contact Person: _____

Telephone Number: _____ FAX Number: _____

Email Address: _____ Website: _____

Description of project, including purpose, date, target population:

Amount Requested: _____ Total Cost of Project: _____

Other sources of funding: _____

Please describe how this grant will impact the health of the community within the scope of the BCHD health priorities.

School affiliated applicants **MUST** get approval from the school principal:

Name: _____ Signature: _____ Date: _____

Please send your completed application to: Charlie Velasquez, Executive Assistant,
Beach Cities Health District, 514 N. Prospect Ave., Redondo Beach, CA 90277

Received by: _____ Date _____

Approved By: _____ Date _____

Denied By: _____ Date _____