



Grant Application

Date of Application: _____

Department or Organization Information:

Department or Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of Lead Contact: _____ Title: _____

Phone: _____ FAX: _____ E-mail: _____

Name of Secondary Contact: _____ Title: _____

Phone: _____ FAX: _____ E-mail: _____

Grant Information:

Program/Project Title/Equipment: _____

Amount of this request: \$ _____ Total Cost for this program: \$ _____

Grant Duration: _____ Anticipated Start Date: _____

Type of Request (check all that apply):	
<input type="checkbox"/> Capital	<input type="checkbox"/> Equipment
<input type="checkbox"/> Technical Assistance	<input type="checkbox"/> Project Start-Up
<input type="checkbox"/> Operating	<input type="checkbox"/> Continuing Education
<input type="checkbox"/> Program	<input type="checkbox"/> Other (please explain):

What other funding avenues have you explored or are exploring for this program/project?

I understand if the grant application is approved, the lead contact is responsible for identifying and securing a testimonial from a patient/participant who has benefited as a result of our department/organization receiving this grant and providing that information to Union Health Foundation when submitting the Grant Outcome Report.

Director : (Print) _____ (Signature) _____ Date: _____

Vice President: (Print) _____ (Signature) _____ Date: _____

Statement of Need:

- What is the problem, challenge or need that is unaddressed or unmet?

- What is the research, statistics or evidence that shows this need or benefit exists?

Desired Outcomes:

- Please describe the changes in individuals or communities due to their participation in this program/project.

- Describe the methods you will use to assess the success of the proposed project.

Program/Project Description:

Please provide below or attach a summary description of the program/project including the goals and objectives. Also include how the grant funds will be used. You may attach supplemental information to support your application.

Demographic Information:

Approximate number of people to be served during grant period: _____

Gender

Female _____ %
 Male _____ %

= should equal 100%
 of the population
 served

Age

Youth (0-17) _____ %
 Adults (18-65) _____ %
 Senior (65+) _____ %

Race

Asian/Pacific Islander _____ %
 Black or African American _____ %
 White or Caucasian _____ %
 Hispanic or Latino _____ %
 American Indian and Alaska Native _____ %
 More than one race _____ %

Annual Income

Low-Income (\$20,000 or Below) _____ %
 Middle-Income (\$20,001 – 60,000) _____ %
 High-Income (\$60,001 or Above) _____ %

Geography

Vigo County _____ %
 Clay County _____ %
 Parke County _____ %
 Vermillion County _____ %
 Edgar County _____ %
 Clark County _____ %
 Sullivan County _____ %
 Crawford County _____ %
 Greene County _____ %
 Other _____ %

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- Incomplete applications will **NOT** be processed.
 - The purchase of all items for hospital departments **MUST** be done through the supply chain department under their guidelines.
 - If this grant is approved, it is for one-time only, not on-going.
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For Union Health Foundation Use Only: ID: # _____ Date Received by Foundation: _____

FOUNDATION ACTION:			
Executive Director:	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	Date:
Grants & Awards Committee:	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	Date:
Board of Directors:	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	Date:
Date of 1st Grant Outcome Report:	Date:	Frequency of Reports	

Please send completed application to: Union Health Foundation 1606 N 7th St Terre Haute IN 47804
 Phone: 812-238-7534 Fax: 812-238-4580 Website: www.unionhospitalfoundation.org