UNION HEALTH
Foundation

www.unionhospitalfoundation.org

Grant Outcome Report

Date of Report: _____ Grant ID#: _____

Department or Organization: _____
Name of Lead Contact: _____
Title: _____
Phone: _____ E-mail: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Program/Project Title: _____
Program/Project Start Date: _____ $ Amount Approved:_____
Communities or Counties Served: _____
Number of people served during grant period: _____
Demographic description of population served:

_____
_____
_____
_____
_____

Program/Project Description:
(Please provide a summary description of the program/project including the goals and objectives. Also include how the grant funds were used. You may attach supplemental information to support your report.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Describe the methods you used to assess the success of the project.

What was the problem, challenge or need that was addressed?

What research, statistics or evidence supports the previous statements?

Report Submitted by:_____ Date:_____

☐ I have attached information that identifies a patient/participant who has benefited as a result of our department/organization receiving this grant along with his/her testimonial and signed consent release form.

For Union Health Foundation Use Only: ID#:_____ Date Received by Foundation:_____

Date Reviewed by Grants and Awards Committee:_____

Date Reviewed by Board of Directors:_____

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

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