Wayne Memorial Health Foundation

*Wayne Memorial Community Grant Program*

2018 APPLICATION FOR SUPPORT

# *Deadline for receipt of completed Application* JUNE 30, 2018

This Application, as well as the Wayne Memorial Health Foundation (WMHF) Community Grant Program Policies and Procedures are available on the Wayne Memorial Hospital website at www.wmh.org.

Completed Applications (all pages and supporting materials) may be delivered, mailed, faxed or scanned and emailed to the address below. Return Applications to:

Wayne Memorial Health Foundation

601 Park Street

Honesdale, PA 18431

Fax: (570) 253-8993 email: [dennis@wmh.org](mailto:dennis@wmh.org)

*(All information regarding your organization that you provide with this Application will be used to determine eligibility for WMHF funding only and will be kept in complete confidence.)*

***IMPORTANT: In accordance with Pennsylvania Corporate Law, WMHF may only award grants to 501(c)3 organizations. Applicant organizations must have proof of 501(c)3 status from the Internal Revenue Service. Either IRS approval, or proof of application for approval, must be included with your application. If 501(c)3 approval is pending, please realize that any approved grant award cannot be dispersed until final approval notification is received from the IRS and submitted to the Foundation.***

*Please check the appropriate response*:

IRS 501(c)3 tax exempt approved [ ] IRS 501(c)3 pending (applied for) [ ]

*Please complete all sections*:

Applicant Organization Street

City/Borough/Township State Zip

Organization Contact Person ­­­­ Phone

Fax Web address: http:// Email

Grant Request (Project) Title

Type of request (check):

[ ] Start-up costs (first year only) [ ] Project/Program support [ ] Operations (related to Project)

Total organizational budget (current year): $ Fiscal year start date:

(Please note that the proposed project or delivery of health-related program services must take place in Wayne Memorial Health System service area of Wayne or Pike Counties, Carbondale or Forest City, PA areas). Please indicate your project/program service area focus:

[ ] Wayne County [ ] Pike County [ ] Carbondale Area [ ] Forest City Area [ ] Other (explain)

Organization Mission Statement:

*[Disclosure: The Wayne Memorial Community Grant Program is considered a mini-grant program. To maximize the impact of the funding available for grant awards, individual award amounts are limited. In order to provide support for nonprofit community health organizations throughout the service area, grant awards will not exceed $5,000, except in special circumstances determined by the WMHF Community Health Committee.]*

**Total of this grant request for Wayne Memorial service area operations: $**

Organization Name

Summary of grant request : (2-3 sentences):

**PROGRAM NARRATIVE (**maximum 7 pages):

Describe your organization:

1. History and major accomplishments:

2. Programs and activities:

3. Service Area:

a. Define the target population and how it will benefit from this project/program:

b. If your organization is affiliated with another organization (e.g., regional, state, or national) indicate that affiliation and the organization’s mission:

c. If you are a grassroots organization, describe how your group was formed and the stages of its development:

d. Describe your Goals, Objectives, Activities, Outcomes, and Evaluation Methods as related to this grant request:

e. Describe the anticipated impact that the proposed project/program would have:

d. Organizations that receive WMHF funding will be required to submit a Progress Report on the use of these funds and outcomes before the end of the funding year. Identify the individual(s) that will be responsible for this report.

Organization Name

**GRANT REQUEST BUDGET:** **Expenses and revenues for Wayne Memorial Health System service area operations only. Total expenses must equal total revenues.**

## EXPENSES REVENUE

**Item Amount Source Amount**

Total Salaries: $ Government

Grants/Contracts $

Staff position (indicate full or part-time):

Foundations

Corporations

Earned income

Individual

Contributions

Fundraising

Total fringe benefits Membership fees

Consultants and Other

professional fees (specify):

Travel

Equipment

Supplies

Printing/copying

Telephone/fax **Total WMHF Request \_\_\_\_\_\_\_\_\_\_\_\_**

Postage **TOTAL**

**REVENUES** $

Rent

Utilities Supplemental Information

Other (specify) In-kind support (specify type):

**TOTAL** TOTAL

**EXPENSES** $ IN-KIND $

Organization Name

**ATTACHMENTS CHECKLIST**

The following items must be included with your application:

\_\_\_\_\_\_ Articles of Incorporation (returning applicants do not have to resubmit this item)

\_\_\_\_\_\_ Proof of 501(c)(3) tax-exempt status –OR– proof of 501(c)(3) application if a new organization

(returning applicants do not have to resubmit this item)

\_\_\_\_\_\_ Two letters of support from a community organization/agency. Limit – two (2) pages.

\_\_\_\_\_\_ Two letters of support from clients of your organization’s services. Limit – two (2) pages.

\_\_\_\_\_\_ List of major funders, including amount of support and any restrictions on the use of funds

\_\_\_\_\_\_ Provide printed samples of your promotional materials (no audio/videotapes, please)

\_\_\_\_\_\_ Provide an organizational financial statement dated within the last 6 months

\_\_\_\_\_\_ Provide the original signed Non-Discrimination Policy below

**Non-discrimination Policy**

(Applicant Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ shall not discriminate on the basis of race, color, religious creed, ancestry, union membership, age, sex, sexual orientation, national origin or mental or physical challenge. Compliance with the Pennsylvania Human Relations Act (43 P.S. 951-963) shall constitute compliance with this paragraph. This policy shall apply to any person served, membership on the Board of Directors and staff employment. Compliance with this policy is required of applicant organizations/agencies in order to receive funding from Wayne Memorial Health Foundation.

Compliance with this policy must be acknowledged by signature of the Executive Director or President of applicant organizations/agencies.

Signature Title

Organization/Agency Date