WAYNE MEMORIAL HEALTH FOUNDATION

Wayne Memorial Community Grant Program

2019 APPLICATION FOR SUPPORT

DEADLINE FOR RECEIPT OF COMPLETED APPLICATION **JUNE 30, 2019**

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

(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: <u>Expenses and revenues for Wayne Memorial Health System service area operations only. Total expenses must equal total revenues.</u>

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 professional fees	_____		Other (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 EXPENSES	$_____		TOTAL 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