WAYNE MEMORIAL HEALTH FOUNDATION

Wayne Memorial Community Grant Program

2020 APPLICATION FOR SUPPORT

DEADLINE FOR RECEIPT OF COMPLETED APPLICATION **JUNE 30, 2020**

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: ____

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[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): ______________________________

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PROGRAM NARRATIVE (maximum 7 pages):

Describe your organization:

1. History and major accomplishments: ______________________________

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2. Programs and activities: ______________________________

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3. Service Area:

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

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

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

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

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

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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 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