Wayne Memorial Health Foundation

*Wayne Memorial Community Grant Program*

2024 APPLICATION FOR SUPPORT

# *Deadline for receipt of completed Application* JUNE 21, 2024

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 (this option is preferred) to the address below to:

Wayne Memorial Health Foundation

Attn: Carol Kneier, Manager of Community Health

601 Park Street

Honesdale, PA 18431

Phone: (570) 253-8422 Fax: (570) 253-8993 email: kneier@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 Wayne Memorial Health 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 ­­­­Click here to enter text. Phone Click here to enter text.

Fax Click here to enter text. Web address: http://Click here to enter text. Email Click here to enter text.

Grant Request (Project) Title Click here to enter text.

Type of request (check):

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

Total organizational budget (current year): $Click here to enter text. Fiscal year start date: Click here to enter text.

(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, WMHF limits individual award amounts. In order to provide support for nonprofit community health-related 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: $**Click here to enter text.

Organization Name: Click here to enter text.

Summary of grant request: (2-3 sentences): Click here to enter text.

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

Describe your organization:

1. History and major accomplishments: Click here to enter text.

2. Programs and activities: Click here to enter text.

3. Service Area: Click here to enter text.

a. Define the target population and how it will benefit from this project/program: Click here to enter text.

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

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

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

e. Describe the anticipated impact that the proposed project/program would have in your community: Click here to enter text.

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. Click here to enter text.

**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: $Click here to enter text. Government

Grants/Contracts $Click here to enter text.

Staff position (indicate full or part-time):

Position Amount

Click here to enter text. Click here to enter text. Foundations Click here to enter text.

Click here to enter text. Click here to enter text. Corporations Click here to enter text.

Click here to enter text. Click here to enter text. Earned income Click here to enter text.

Individual

Click here to enter text. Click here to enter text. Contributions Click here to enter text.

Click here to enter text. Click here to enter text. Fundraising Click here to enter text.

Total fringe benefits Click here to enter text. Membership fees Click here to enter text.

Consultants and Other

professional fees Click here to enter text. (specify):

Travel Click here to enter text. Click here to enter text. Click here to enter text.

Equipment Click here to enter text. Click here to enter text. Click here to enter text.

Supplies Click here to enter text. Click here to enter text. Click here to enter text.

Printing/copying Click here to enter text. Click here to enter text. Click here to enter text.

Telephone/fax Click here to enter text. **Total WMHF Request $** Click here to enter text.

Postage Click here to enter text. **TOTAL**

**REVENUES** $ Click here to enter text.

Rent Click here to enter text.

Utilities Click here to enter text. Supplemental Information

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

Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text.

Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text.

**TOTAL** TOTAL

**EXPENSES** $Click here to enter text. IN-KIND $ Click here to enter text.

**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) Click here to enter text. shall not discriminate on the basis of race, color, religion, 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.

Click here to enter text.

Signature Title

Click here to enter text. Click here to enter text.

Organization/Agency Date