**WAYNE MEMORIAL HEALTH FOUNDATION**

# *Wayne Memorial Community Grant Program*

## 2025 APPLICATION FOR SUPPORT

***DEADLINE FOR RECEIPT OF COMPLETED APPLICATION*** **JUNE 27, 2025**

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 _____ 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, 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: $_____**

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 in your community:

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. _____

**ORGANIZATIONAL NAME** _____

**GRANT REQUEST BUDGET: <u>Expenses and revenues for Wayne Memorial Health Foundation grant proposal only and not your organization's budget. 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 | $ _____ |

## 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, 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.

_____ _____

Signature Title

_____ _____

Organization/Agency Date