UNION HEALTH Foundation

Grant Application

Date of Application: _____

Department or Organization Information:

Department or Organization: _____

Address: _____
City: _____ State: _____ Zip Code: _____

Name of Lead Contact: _____Title: _____
Phone: _____ FAX: _____ E-mail: _____

Name of Secondary Contact: _____Title: _____
Phone: _____ FAX: _____ E-mail: _____

Grant Information:

Program/Project Title/Equipment: _____

Amount of this request: $_____ Total Cost for this program: $ _____
Grant Duration: _____ Anticipated Start Date: _____

Type of Request (check all that apply):	
☐ Capital	☐ Equipment
☐ Technical Assistance	☐ Project Start-Up
☐ Operating	☐ Continuing Education
☐ Program	☐ Other (please explain):

What other funding avenues have you explored or are exploring for this program/project?

☐ I understand if the grant application is approved, the lead contact is responsible for identifying and securing a testimonial from a patient/participant who has benefited as a result of our department/organization receiving this grant and providing that information to Union Health Foundation when submitting the Grant Outcome Report.

Director : (Print) _____ (Signature) _____ Date: _____

Vice President: (Print) _____ (Signature) _____ Date: _____

Statement of Need:

- What is the problem, challenge or need that is unaddressed or unmet?

- What is the research, statistics or evidence that shows this need or benefit exists?

Desired Outcomes:

- Please describe the changes in individuals or communities due to their participation in this program/project.

- Describe the methods you will use to assess the success of the proposed project.

Program/Project Description:

Please provide below or attach a summary description of the program/project including the goals and objectives. Also include how the grant funds will be used. You may attach supplemental information to support your application.

Demographic Information:

Approximate number of people to be served during grant period: _____

Gender		
	Female	_____ %
	Male	_____ %
		= should equal 100% of the population served
Age		
	Youth (0-17)	_____ %
	Adults (18-65)	_____ %
	Senior (65+)	_____ %
Race		
	Asian/Pacific Islander	_____ %
	Black or African American	_____ %
	White or Caucasian	_____ %
	Hispanic or Latino	_____ %
	American Indian and Alaska Native	_____ %
	More than one race	_____ %
Annual Income		
	Low-Income ($20,000 or Below)	_____ %
	Middle-Income ($20,001 – 60,000)	_____ %
	High-Income ($60,001 or Above)	_____ %
Geography		
	Vigo County	_____ %
	Clay County	_____ %
	Parke County	_____ %
	Vermillion County	_____ %
	Edgar County	_____ %
	Clark County	_____ %
	Sullivan County	_____ %
	Crawford County	_____ %
	Greene County	_____ %
	Other	_____ %

- Incomplete applications will **NOT** be processed.
- The purchase of all items for hospital departments **MUST** be done through the supply chain department under their guidelines.
- If this grant is approved, it is for one-time only, not on-going.

For Union Health Foundation Use Only: ID: # _____ Date Received by Foundation: _____

FOUNDATION ACTION:			
Executive Director:	☐ Approved	☐ Declined	Date:
Grants & Awards Committee:	☐ Approved	☐ Declined	Date:
Board of Directors:	☐ Approved	☐ Declined	Date:
Date of 1st Grant Outcome Report:	Date:	Frequency of Reports	

Please send completed application to: Union Health Foundation 1606 N 7th St Terre Haute IN 47804
Phone: 812-238-7534 Fax: 812-238-4580 Website: www.unionhealthfoundation.org

Rev. 1/24/17