Navicent Health Foundation

ENCOURAGING YOUR GENEROSITY TO TRANSFORM VISIONS INTO REALITY
P O Box 7718, Macon, GA 31209
478-633-4483

COMMUNITY HEALTH GRANT APPLICATION

(Application must be typed. Please complete all parts of the application. If sections are not applicable, please mark N/A.)

LEGAL NAME OF PROPOSING ORGANIZATION:

TAX ID NUMBER:

CONTACT PERSON (Name and Title):

ADDRESS :

TELEPHONE:

FAX NUMBER:

PROPOSED PROJECT (Title or use of grant monies):

AMOUNT OF GRANT REQUESTED FROM NAVICENT HEALTH FOUNDATION: $________________

TOTAL COST OF PROJECT: $________________

CEO, BOARD EXECUTIVE OR OFFICER ASSURANCE: I am authorized to sign and accept responsibility for the supervision, performance, and reporting requirements of this project if an award is made. I have not previously performed or reported on this proposal. I certify that the information contained in this application and any documents attached to this application are current, true and valid. I understand any funds granted must be expended solely for the purpose(s) set out in this proposal. I understand that in the event that any grant or any portion is determined to be a non-qualifying distribution, repayment of same will be made.

____	________________	________________
SIGNATURE OR OFFICER SIGNING FOR PROPOSING ORGANIZATION	TITLE	DATE

Please define the problem being address; the primary objective of the proposal; how the proposal will address the unmet need(s) and is new, innovative or collaborative.

Please define the expected outcomes and benefits of the project

TOTAL PROJECT BUDGET

NOTE: Please reflect total costs for your project even if it exceeds the amount requested. Please attach budget to application.

TOTAL GRANT REQUEST FROM NAVICENT HEALTH FOUNDATION: $________________

TOTAL GRANT REQUEST FROM ADDITIONAL SOURCES: * $_________________

TOTAL PROJECT COST: $______________ (Total request from Navicent Health Foundation and request from additional sources must equal total project cost.)

* If this project is seeking additional sources of funding, list each source and amount below.

If charges for services will be made or fees will be required of participants, please state anticipated annual revenues: $___________.

Please explain how these revenues will be derived.

COMMUNITY HEALTH GRANT
APPLICATION CHECK LIST - PLEASE COMPLETE

COMPLETED APPLICATION Yes_____ No_____

INTERNAL REVENUE SERVICE TAX EXEMPT LETTER(S) Yes_____ No_____

ORGANIZATION'S CURRENT ANNUAL OPERATING BUDGET INCLUDING REVENUES AND EXPENSES Yes_____ No_____

MOST RECENT AUDITED FINANCIAL STATEMENT Yes_____ No_____

PROJECT BUDGET Yes_____ No_____

____________________	____________________	____________________
SIGNATURE	TITLE	DATE

FOUNDATION USE ONLY

DATE APPLICATION RECEIVED: ________________________________

NHF BOARD RECOMMENDATION: APPROVAL DISAPPROVAL

IF APPROVED, APPROVAL AMOUNT: $____________________

CHECK ISSUED TO:________________________________

DATE ISSUED:________________________________

REPORTING REQUIREMENTS:________________________________

NAVICENT HEALTH FOUNDATION CHIEF DEVELOPMENT OFFICER

SIGNATURE ________________________________

DATE________________________________