

Navicent Health Foundation

ENCOURAGING YOUR GENEROSITY TO TRANSFORM VISIONS INTO REALITY

HEALTHCARE EMPLOYEES ACHIEVING TOMORROW

- GRANT APPLICATION -

Please submit to:
H.E.A.T. TRUST GRANT ALLOCATIONS COMMITTEE
c/o Navicent Health Foundation
PO Box 7718
Macon, GA 31209
Phone: 478-633-7395

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

Legal Name of Organization:

Tax ID Number:

Contact (Name & Title):

Address:

City:

State:

Zip:

Phone:

E-mail:

Proposed Project:

Name/Title of Program or Project for which grant is requested

Amount Requested (Up to \$10,000.00):

Total Estimated Project Cost:

Department/Program Director, CEO, Board Executive or Officer Assurance: Should this organization be awarded a grant from the H.E.A.T. Trust Fund, I certify that I am authorized to sign and accept responsibility for the supervision, performance, and reporting requirements of the funded project, and that 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, and that in the event any grant or any portion is determined to be a non-qualifying distribution, repayment of same will be made.

Name of Authorized Representative of Proposing Organization

Title

Signature of Above-Named Representative

Date

Part I: Clearly and briefly define the issue your project addresses and explain why it is compelling and worthy of funding. Please include the impact of your project.

Part II: Please list other community partnerships and/or collaborative efforts established by the organization specifically to benefit the proposed project.

NOTE: Having no other collaborations or partnerships to list below WILL NOT disqualify the application from consideration.

Organization Name & Address	Contact Name & Phone	Description of Partnership

Part III: Total Project Budget

NOTE: Please indicate all costs for your project even if the total exceeds the amount requested.
 Be as specific as possible. You may attach supplemental pages if necessary.

CATEGORY	AMOUNT	ITEM(S)	JUSTIFICATION
Marketing/Promotion Expenses			
Itemized Equipment Expenses			
Itemized Supply/Food Expenses			
Stipend/Honorarium Expenses			
Other Expenses			
TOTAL:			

Additional Funding/Revenue Sources:

(i.e., other grants, contributions, fees, etc., expected):

<u>Funding Source</u>	<u>Amount Anticipated</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
Total Additional Funding Expected:	\$ _____

Total Project Cost: \$ _____

Total Amount Requested* from H.E.A.T. Trust Fund: \$ _____

* Total Additional Funding and Revenue plus Total Amount Requested from H.E.A.T. must not exceed Total Project Cost.

Part IV: Prior Grant Reporting

Did the organization receive a grant from the Navicent Health Foundation in the prior grant year?

Yes No

Amount:

Purpose: in a sentence, please summarize the purpose of funds granted

Report: one-page written narrative and an example explaining or showing how the program has made a difference in the lives of the people who are served by the organization.



Supporting Documentation Required*

The following list indicated supporting documents that **must** be included in your application packet in order to be considered for HEAT Grant funding. Please complete and sign this form to verify that all required documents are included, and return attached to top of application.

** Exception: Navicent Health departments/programs are only required to complete the application.*

Have you enclosed the following?

- | | | |
|--|-----|----|
| 1. COMPLETED APPLICATION: | Yes | No |
| 2. INTERNAL REVENUE SERVICE TAX EXEMPT LETTER(S): | Yes | No |
| 3. CURRENT ANNUAL OPERATING BUDGET:
(Must include revenues & expenses) | Yes | No |
| 4. MOST RECENT AUDITED FINANCIALS and/or 990 | Yes | No |
| 5. BOARD OF DIRECTORS LIST: | Yes | No |

HAVE YOU EVER RECEIVED/ARE CURRENTLY RECEIVING MONIES/ SPONSORSHIPS FROM MEDCEN/NAVICENT HEALTH FOUNDATION, THE MEDICAL CENTER OR NAVICENT HEALTH?

Yes No

IF YES, PLEASE EXPLAIN:

HAVE YOU EMAILED A COPY TO TARVER.PERRY@ATRIUMHEALTH.ORG? Yes No

Signature & Title of Organization Representative

Date

- FOR FOUNDATION USE ONLY -

Date Received:

Date of Committee Review:

Recommendation of H.E.A.T. Trust Grant Allocations Committee:

Approved (Amount: \$)

Denied

Conditions of Approval (if any):

Explanation:

Navicent Health Foundation Board of Trustees - Action on Recommendation:

Approved (Amount: \$)

Not Approved

Date of
Applicant Notification:

Date of
Check Issue:

Check
Issued to:

Special Reporting Requirements (if any):