Navicent Health Foundation

ENCOURAGING YOUR GENEROSITY TO TRANSFORM VISIONS INTO REALITY

HEALTHCARE EMPLOYEES ACHIEVING TOMORROW

Please submit to:
tarver.perry@atriumhealth.org
or
H.E.A.T. TRUST GRANT ALLOCATIONS COMMITTEE
c/o Navicent Health Foundation
3330 Northside Drive
Macon, GA 31210
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**

Is the grant request submitted by AHN leaders or teammates or does the grant directly impact or require participation by ANH teammates, service lines or entities? yes no

If yes, approval required by Atrium Health President

______________________________ ______________________________
Signature of Atrium Health Navicent President **Date**

<u>Part I</u>: **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):

Funding Source | Amount Anticipated

______ $ ______

______ $ ______

______ $ ______

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

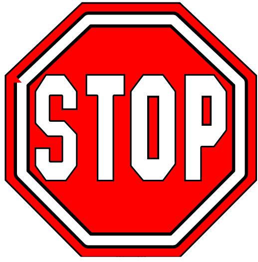
Did the organization receive a grant from the Navicent Health Foundation in the prior grant year?

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?

		Yes	No
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.	**AUDITED FINANCIALS IF REQUIRED BY LAW OR 990 IF AUDIT IS NOT REQUIRED FOR YOUR ORGANIZATION:**	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):