Navicent Health Foundation

ENCOURAGING YOUR GENEROSITY TO TRANSFORM VISIONS INTO REALITY

COMMUNITY HEALTH GRANT APPLICATION

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

Please submit to tarver.perry@atriumhealth.org or
3330 Northside Dr. Ste. 100, Macon, GA 31210
478-633-4483

LEGAL NAME OF PROPOSING ORGANIZATION:

TAX ID NUMBER:

CONTACT PERSON (Name and Title):

ADDRESS :

TELEPHONE:

EMAIL ADDRESS

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

Is the grant request submitted by AHN leaders or teammates? If yes, approval required by Atrium Health Navicent President

YES ◯ NO ◯

_____ _____

SIGNATURE OF ATRIUM HEALTH PRESIDENT 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 IF REQUIRED BY LAW OR 990 IF AUDIT IS NOT REQUIRED FOR YOUR ORGANIZATION 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:_____

TO BE ISSUED FROM FUND: _____

NAVICENT HEALTH FOUNDATION PRESIDENT/CEO

SIGNATURE _____

DATE_____