

# 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: 478-633-6189

**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:**  **FAX**:       **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 use normal spacing and font size, and do not exceed this page.)

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.

## 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:** [ ]  Yes [ ]  No

(Must include revenues & expenses)

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HAVE YOU EMAILED A COPY TO GILREATH.NENA@NAVICENTHEALTH.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 Date of Check

Applicant Notification:       Check Issue:       Issued to:

Special Reporting Requirements (if any):