UNION HOSPITAL

SERVICE LEAGUE

Incomplete applications will not be reviewed:

Date of Application: ________________ | Date Received by Service League:____________

Department or Organization Information:

Department or Organization: ____

Address: ____

City: ______________________________ State: __________ Zip Code: __________

Name of Lead Contact: ______________________________Title: __________________

Phone: __________________ FAX: __________________ E-mail: ____________________________

Name of Secondary Contact: ____________________________Title: __________________

Phone: __________________ FAX: __________________ E-mail: ____________________________

Grant Information:

*Please provide detailed cost information on items requested. Hospital purchasing procedures must be adhered to on all requests.

Program/Project Title / Equipment:____

Amount of Request: $____________________ Total Cost for this program: $________________

Grant Duration: ________________________ Anticipated Start Date: ______________________

Type of Request (check all that apply):	
Capital	Equipment
Technical Assistance	Project Start-Up
Operating	Continuing Education
Program	Other (please explain):

What other funding avenues have you explored or are exploring for this program/project?

Director: (Print)________________________ (Signature) ________________________ Date: ______________

Vice President: (Print)________________________ (Signature) ________________________ Date: ______________

Statement of Need:

- What is the problem, challenge or need that is unaddressed or unmet?
- What is the research, statistics or evidence that shows this need or benefit exists?

Desired Outcomes:

- Please describe the changes in individuals or communities due to their participation in this program/project.
- Describe the methods you will use to assess the success of the proposed project.

Program/Project Description:

Please provide below or attach a summary description of the program/project including the goals and objectives. Also include how the grant funds will be used. You may attach supplemental information to support your application.

Demographic Information:

Approximate number of people to be served during grant period: ______________

Gender		
	Female	_______ %
	Male	_______ %
		= should equal 100% of the population served
Age		
	Youth (0-17)	_______ %
	Adults (18-65)	_______ %
	Senior (65+)	_______ %
Race		
	Asian/Pacific Islander	_______ %
	Black or African American	_______ %
	White or Caucasian	_______ %
	Hispanic or Latino	_______ %
	American Indian and Alaska Native	_______ %
	More than one race	_______ %
Annual Income		
	Low-Income ($20,000 or Below)	_______ %
	Middle-Income ($20,001 – 60,000)	_______ %
	High-Income ($60,001 or Above)	_______ %
Geography		
	Vigo County	_______ %
	Clay County	_______ %
	Parke County	_______ %
	Vermillion County	_______ %
	Edgar County	_______ %
	Clark County	_______ %
	Sullivan County	_______ %
	Crawford County	_______ %
	Greene County	_______ %
	Other	_______ %

- Incomplete applications will **NOT** be processed.
- The purchase of all items for hospital departments **MUST** be done through the supply chain department under their guidelines.
- If this grant is approved, it is for one-time only, not on-going.

For Union Health Foundation Use Only: ID: # _______________ Date Received by Foundation: ______________

SERVICE LEAGUE A**CTION:**			
Wish List Committee:	☐ Approved	☐ Declined	Date:
Service League Board:	☐ Approved	☐ Declined	Date:
	Date:	Frequency of Reports	

Please send completed application to: Union Hospital Volunteer Services 1606 N 7th St Terre Haute IN 47804
Attention: Susan Grutza Phone: 812-238-7674

Rev. 7/12/16