



Date of Report: \_\_\_\_\_

Grant ID#: \_\_\_\_\_

Department or Organization: \_\_\_\_\_

Name of Lead Contact: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Program/Project Title: \_\_\_\_\_

Program/Project Start Date: \_\_\_\_\_ \$ Amount Approved: \_\_\_\_\_

Communities or Counties Served: \_\_\_\_\_

Number of people served during grant period: \_\_\_\_\_

Demographic description of population served:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Program/Project Description:

(Please provide a summary description of the program/project including the goals and objectives. Also include how the grant funds were used. You may attach supplemental information to support your report.)

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Outcomes:**

Please describe the changes in individuals or communities due to their participation in this program/project.

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Describe the methods you used to assess the success of the project.

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What was the problem, challenge or need that was addressed?

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What research, statistics or evidence supports the previous statements?

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Report Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

I have attached information that identifies a patient/participant who has benefited as a result of our department/organization receiving this grant along with his/her testimonial and signed consent release form.

For Union Health Foundation Use Only: ID#: _____ Date Received by Foundation: _____
Date Reviewed by Grants and Awards Committee: _____
Date Reviewed by Board of Directors: _____

Please send completed report to: Union Health Foundation 1606 N 7th St Terre Haute IN 47804  
Phone: 812-238-7534 Fax: 812-238-4580 Website: [www.unionhospitalfoundation.org](http://www.unionhospitalfoundation.org)