H.E.A.T. TRUST FUND

HEALTHCARE **E**MPLOYEES **A**CHIEVING **T**OMORROW

THE MEDICAL CENTER OF CENTRAL GEORGIA & CENTRAL GEORGIA HEALTH SYSTEM

- GRANT APPLICATION -

Please submit to:

H.E.A.T. TRUST GRANT ALLOCATIONS COMMITTEE
c/o Medcen Community Health Foundation
MSC 78
858 High Street, Macon, GA 31201
Phone: 478-633-7396

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 and Title

Address: ______________________________
No. & Street or PO Box City State Zip

Phone: ________________ **FAX**: ________________ **E-mail:** ______________________________

Proposed Project: ______________________________
Name/Title of Program or Project for which grant is requested

Amount Requested (Up to $3,000.00)**: $** ____________ **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**

Organization Name: ______________________________ Project Title: ______________________________

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.)

Organization Name: ______________________________ Project Title: ______________________________

<u>Part II</u>: Please describe the primary goals and objectives of the project, detailing how the project addresses unmet needs, and whether the grant monies would be used to help fund a new project, or enhance and/or expand to a higher level and existing program.

(Please use normal spacing and font size, and do not exceed this page.)

Organization Name: ______________________________ Project Title: ______________________________

Part III: Please list other community partnerships and/or collaborative efforts established by the organization specifically to benefit the proposed project.

NOTE: Having no other 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 IV: How have these partnerships and/or collaborative efforts been significant In helping to address the need your project targets?

(Please use normal spacing and font size, and do not exceed this page.)

Organization Name: ______________________________ Project Title: ______________________________

Part V: Define the expected benefits and outcomes of the project, and the anticipated impact of the project on community health.

(Please use normal spacing and font size, and do not exceed this page.)

Organization Name: ______________________________ Project Title: ______________________________

Part VI: 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
Capital Expenses			
Itemized Equipment Expenses			
Itemized Supply Expenses			
Salary Expenses			
Other Expenses			
TOTAL:			

Additional *Funding* Sources:

(E.g., other grants, contributions, etc., expected):

Funding Source	Amount Anticipated
______________________	$ __________
______________________	$ __________
______________________	$ __________

Total Additional Funding Expected: $ __________

Additional *Revenue* Sources:

(E.g., service charges, fees, etc., applicable to project participants):

Revenue Source	Amount Anticipated
______________________	$ __________
______________________	$ __________
______________________	$ __________

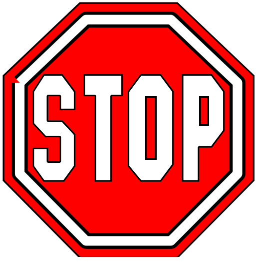
Total Additional Revenue Expected: $ __________

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.

Organization Name: ______________________ Project Title: ______________________



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: MCCG departments/programs* **are not** *required to submit IRS tax-exempt letter (see #2) or audited financial statement (see #4).*

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:** (Must include revenues & expenses)	❒ Yes	❒ No
4.	**MOST RECENT AUDITED FINANCIAL STATEMENT:**	❒ Yes	❒ No
5.	**BOARD OF DIRECTORS LIST:**	❒ Yes	❒ No
	HAVE YOU EMAILED A COPY TO TERRELL.ELLEN@MCCG.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: $ __________)

Conditions of Approval (if any): ______________

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____

❒ **Denied**

Explanation: ______________________

____

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Medcen 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): ______________________________