**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 APPLICATION CHECKLIST**

Review this Checklist as the first step in preparing your Application, and once again before submitting your Application to make sure it is complete.

|  |
| --- |
| * Please do not use binders, folders, or covers.
* Secure multiple pages with staples or binder clips.
* Your answers are limited to the space provided (do not expand the allotted answer space or add additional pages).
* Your answers must be single-spaced in 12-point font.
 |

**APPLICATION**

**[ ]  Please submit one (1) original Application Form,** signed by the ExecutiveDirector/CEO and/or the Board Chair, and marked “ORIGINAL.” Mail or deliver your complete application to:

 Premier Health Patient Care Services, Attn: Shaun Hamilton, 110 N. Main Street, Suite 900, Dayton, Ohio 45423.

 **[ ]  Please also submit your application via email as a Word document to** sbhamilton@premierhealth.com The emailed application must be received by 4:00 p.m. on the deadline date.

**ATTACHMENTS: one copy of each of the following with mailed packet (not as email attachments)**

**[ ]** Copy of most recent complete audit, including auditor’s notes
If the organization does not have an audit, then send most recent 990.

[ ]  Most recent IRS Form 990

[ ]  Copy of your organization’s diversity policy

[ ]  If request is $10,000 or above, please provide letters of financial support for collaboration efforts in section 4.3

**To be considered, the application package must be complete per this checklist. Applications must be postmarked on or before the deadline date. Incomplete or late proposals will not be reviewed. Premier Health staff is NOT authorized to extend the application deadline.**

**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 APPLICATION**

**Application Deadline:** [ ]  March 4, 2019 [ ]  August 26, 2019

**I. GENERAL INFORMATION**

|  |  |
| --- | --- |
| **Organization Name:**      | **Federal Tax ID#:**      |
| **Mailing Address:**     **City, State, Zip Code:**      | **Executive Director/CEO:**      |
| **Organization Phone Number:**      | **Executive Director/CEO E-mail Address:**      |
| **Website Address:**      | **Organization’s Current Annual Budget:**      |
| **Amount Requested from Premier Health:**      | **Project/Program Budget:**      |
| **Name and Title of Contact for this Application:**      | **Contact Phone Number and E-mail Address:**      |
| **Purpose of Proposal (state the purpose of your proposal/request in no more than two sentences)**      |
| **Program Area:** **Mark no more than THREE health priorities and subcategories that best applies to this PROPOSAL:****Behavioral Health/Substance Abuse** **Chronic Diseases Birth Outcomes** [ ]  Depression [ ]  Heart Disease [ ]  Preterm Births [ ]  Suicide [ ]  Obesity [ ]  Low Birthweight [ ]  Drug Dependence/Abuse [ ]  Diabetes [ ]  Infant Mortality [ ]  Drug Overdose [ ]  Food Insecurity/Food Deserts [ ]  Lung Cancer [ ]  Breast Cancer [ ]  HIV/ AIDS[ ]  Other (Please Define)       |

**II. PROJECT/INITIATIVE DESCRIPTION**

**2.1 The Issue or Need**: Describe the issue or need the funds will help to address and how it was identified.

|  |
| --- |
|       |

**2.2 The Population and Geographic Region Served by This Program/Initiative:** Describe the population (ethnicity, economic status, age, etc.) and geographical region that are the focus of the proposal, preferably using percentages if available.

|  |
| --- |
|       |

* 1. **The Strategy:** State specifically how this project/initiative will help to improve the issue or need. How will you attract people to participate in the project/ initiative?

|  |
| --- |
|       |

**III. PROFILE OF YOUR ORGANIZATION**

* 1. Overview of your organization, including the mission/purpose and age of organization:

|  |
| --- |
|  |

* 1. Brief description of your current programs/projects and activities:

|  |
| --- |
|  |

* 1. Describe the population (ethnicity, economic status, age, etc.) and geographic region served by existing programs, preferably using percentages if available:

|  |
| --- |
|  |

**IV. FUNDING AND SUPPORT**

* 1. **Other Support for This Project:** Premier Health generally requires additional funding sources for any projects we support. Please list below the other funds that have been received, are pending, or are potential for this project.

**Funds Received or Committed:**

|  |  |  |  |
| --- | --- | --- | --- |
| Source | Amount | DateCommitted | Conditions/Purpose |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Requests Pending:**

|  |  |  |  |
| --- | --- | --- | --- |
| Source | Amount | Expected Response Date | Conditions/Purpose |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Potential/Prospective Funders:**

|  |  |  |  |
| --- | --- | --- | --- |
| Source | Amount | Expected Response Date | Conditions/Purpose |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**4.2 Financial Sustainability:** This discretionary funding does not commit to continued funding. If this project will be ongoing, outline your plan to secure funding support, once these funds are expended.

|  |
| --- |
|       |

**4.3 Collaboration:** Will the organization collaborate with other organizations on this program/initiative**?** (If so, with whom and how?)

|  |
| --- |
|       |

**V. EVALUATION**

* 1. What are your goals and objectives for this program/initiative?

|  |
| --- |
|       |

* 1. What are the measurable short term and long term outcomes of this program/project and how will the outcomes be measured?

|  |  |  |
| --- | --- | --- |
| **OUTCOME****DETAILS** | **HOW WILL OUTCOME BE MEASURED?** | **SHORT-TERM (S)****LONG-TERM (L)** |
| 1.       |       |       |
| 2.       |       |       |
| 3.       |       |       |
| 4.       |       |       |
| 5.       |       |       |
| 6.       |       |       |
| 7.       |       |       |
| 8.       |       |       |

**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 GRANT APPLICATION**

1. **FINANCIAL INFORMATION**
	1. **STATEMENT OF REVENUE AND EXPENSE FOR MOST RECENTLY
	COMPLETED FISCAL YEAR**

**Name of Agency:**

**Time Period:**

|  |
| --- |
| **REVENUE/SUPPORT** |
| Corporate and foundation grants |       |
| Government grants and contracts |       |
| Contributions and other gifts |       |
| United Way |       |
| Program service fees |       |
| Special events, fundraisers |       |
| Other revenue (please list): |       |
|  |       |
|  |       |
|  |       |
|  |       |
|  |       |
| **Total Revenue** | $0.00 |
| **EXPENSES** |
| Salaries, employee benefits and taxes |       |
| Professional fees and/or client assistance |       |
| Occupancy/rent |       |
| Depreciation |       |
| Development/marketing |       |
| General operating expenses (please list): |       |
|  |       |
|  |       |
|  |       |
|  |       |
|  |       |
| **Total Expenses** | $0.00 |
| REVENUE LESS EXPENSES | $0.00 |

**If expenses exceeded revenues, please explain.
Accompanying one-page narrative welcome if additional explanation is warranted.**

|  |
| --- |
|  |

**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 APPLICATION**

**6.3 TOTAL ORGANIZATION BUDGET FOR CURRENT FISCAL YEAR**

**Name of Agency:**

**Time Period:**

|  |  |  |
| --- | --- | --- |
| **REVENUE/SUPPORT** | **Budget for Year** | **Actual Year–To-Date (specify date** **)** |
| Corporate and foundation grants |       |       |
| Government grants and contracts |       |       |
| Contributions and other gifts |       |       |
| United Way |       |       |
| Program service fees |       |       |
| Special events, fundraisers |       |       |
| Other revenue (please list): |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
| **Total Revenue** | $0.00 | $0.00 |
| **EXPENSES** |  |  |
| Salaries, employee benefits and taxes |       |       |
| Professional fees and/or client assistance |       |       |
| Occupancy/rent |       |       |
| Depreciation |       |       |
| Development/marketing |       |       |
| General operating expenses (please list): |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
| **Total Expenses** | $0.00 | $0.00 |
| REVENUE LESS EXPENSES | $0.00 | $0.00 |

**If expenses exceed revenues, please explain how difference will be offset.
Accompanying one-page narrative welcome if additional explanation is warranted.**

|  |
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**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 APPLICATION**

**6.1A PROJECT/PROGRAM REQUEST BUDGET**

**Name of Agency:**

**Time Period:**

|  |
| --- |
| (*Items typical for operating a program)* |
| **REVENUE** | **BUDGET** |
| Corporate and foundation grants |       |
| Government grants and contracts |       |
| Contributions and other gifts |       |
| United Way |       |
| Program service fees |       |
| Special events, fundraisers |       |
| Other revenue (please list): |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **Total Revenue** | $0.00 |
| **EXPENSES** |  |
| Salaries, employee benefits and taxes |       |
| Professional fees and/or client assistance |       |
| Occupancy/rent |       |
| Depreciation |       |
| Development/marketing |       |
| General operating expenses (please list): |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **Total Expenses** | $0.00 |
| **REVENUE LESS EXPENSES** | $0.00 |

**If expenses exceed revenues, please explain how difference will be offset.
Accompanying one-page narrative welcome if additional explanation is warranted.**

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**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 APPLICATION**

**6.1B CAPITAL REQUEST BUDGET (*complete only if request is for capital campaign*)**

**Name of Agency:**

**Time Period:**

|  |  |
| --- | --- |
| **REVENUE** | **BUDGET** |
| Corporate and foundation grants |       |
| Government grants and contracts |       |
| Contributions and other gifts |       |
| United Way |       |
| Program service fees |       |
| Special events, fundraisers |       |
| Other revenue (please list): |       |
|  |       |
|  |       |
|  |       |
|  |       |
|  |       |
| **Total Revenue** | $0.00 |
| **EXPENSES** |  |
| Infrastructure (HVAC, etc.) |       |
| Installations |       |
| Site preparations |       |
| Furnishings |       |
| Professional fees |       |
| Contingency |       |
| Development/Marketing |       |
| Other: |       |
|  |       |
|  |       |
|  |       |
|  |       |
|  |       |
| **Total Expenses** | $0.00 |
| REVENUE LESS EXPENSES | $0.00 |

**If expenses exceed revenues, please explain how difference will be offset. Accompanying one-page narrative welcome if additional explanation is warranted.**

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**PREMIER HEALTH DISCRETIONARY FUND APPLICATION**

**2019 GRANT APPLICATION**

**VII. ACKNOWLEDGEMENT OF THE PREMIER HEALTH DISCRETIONARY FUND APPLICATION POLICIES**

The Executive Director/CEO and Board Chair have reviewed this application and understand and
assure that:

* The applicant is eligible for funding and requests support for activities eligible for funding. (Please see the Application Guidelines for details);
* The final program and financial reports for previous applications have been filed before submitting this application;
* This application is complete per the *Application Checklist*;
* The Premier Health Community Benefits Subcommittee reserves the right to review your application with community planning agencies, resource people, and/or other funding sources. This can occur when we think that their input would be helpful in assessing your proposal and its potential significance;
* Premier Health will notify applicants in writing of its decision. Fund recipients will need to return a signed acceptance document prior to the release of funds. Recipients also must agree to adhere to the terms of the fund throughout the fund period. A final program and financial report are required upon completion of the initiative or as requested by Premier Health.
* This application is part of an open competition. Applications are selected for more detailed evaluation **based on the contents of this application form**. The applicant has clearly and completely described its mission, programs, populations served, request for funding, strategy and impact through anticipated outcomes on this form;
* Organizations that are declined may apply again by the next deadline, if they wish. Organizations that are funded are eligible to apply again after the funds have been paid and the final report has been submitted and approved; and,
* If an organization’s final report is past due and no attempt has been made by the organization to extend the final report deadline, the organization will become ineligible to apply for a grant for a period determined by.

**Executive Director/CEO/or Other Authorized Date**

**Organization Representative**

**Board Chair or Other Board Representative Date**

CONTACT PERSON FOR THIS APPLICATION:

Name Title

Phone Number and Extension E-mail Address