July, 2010

OMHS COMMUNITY BENEFIT

GRANT APPLICATION

PROJECT NAME: ____ **DATE:** _______________

I. Organization Information

What is the Mission and Vision of your organization?

Brief summary of organization's history and significant accomplishments:

Description of current programs and activities (other than proposed project):

Briefly describe the amount and source(s) of funding for your annual budget:

II. Collaboration with Owensboro Medical Health System

Owensboro Medical Health System groups/individuals involved, if any, in your organization:

Name	Title	OMHS Department/Facility

Past or Current In-kind/Financial contribution(s) by Owensboro Medical Health System, if any

Date/Year	Amount	Name of Program/Project
	$	
	$	
	$	

Owensboro Medical Health System
Community Benefit
Going forward. By giving back.

PROJECT NAME: ______________________________ **DATE:** ______________

III. Community Benefit Fund Category Questions

Community Benefit Annual Fund Applicants –

(The following questions are to be answered only if you are applying under the Community Benefit Annual Fund category.)

What identified and documented community health need does this request address?

Please list relevant reference or data source(s) used to identify this community need:
(Refer to OMHS Community Benefit Grant Application Guidelines for sources.)

Community Building Annual Fund Applicants –

(The following questions are to be answered only if you are applying under the Community Building Annual Sponsorship Fund category.)

How will this program/project address the root causes of health problems or improve the health of our community?

What specific benefit is being provided to the underprivileged as a part of this project/program?
(Priority is given to programs and activities that include a benefit for the underprivileged. This may include, for example, free admission to the event or activity by the targeted population.)

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IV. Program/Project Information

Program/Project Title:

Location of the program/project:

Amount requested in proposal: $ Total program/project budget: $ Total agency budget: $

Geographic area(s) to be served:
(Proposals must serve one or more counties in the OMHS Service Area: Daviess, Breckinridge, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio and Webster counties in Kentucky, Spencer and Perry counties in Indiana)

Total number of persons to be served by this program/project:

Who/What is the target population to be served by this project/activity?

Community Partners (List and describe active collaboration with other partners *pertaining to this request*):

Description of the proposed program/project:

GOAL: state your program/project goal

OBJECTIVES: State your measurable objectives and include strategies to meet them.

Provide key steps and timeline for project implementation:

Describe your plan to evaluate your program/project.
(How will you measure objectives and impact of your program?)
If funded, you will be asked to submit a midpoint evaluation and end-of-year grant report.

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Your signature below confirms your agreement to provide a verbal presentation regarding this application, if requested, before OMHS grant reviewers. If funded, you also agree to allow OMHS to reference your organization in material about the Community Benefit Program.

Name/Title (please print) ____

Authorized Signature: ____

Date: ____

Please submit four (4) copies of your completed proposal and attachments to:

Owensboro Medical Health System Community Benefit Program

Community and Government Affairs
P.O. Box 20007
Owensboro, KY 42304-0007