Community Partnership Grant Application

Please send by email to lfrysinger@wellspan.org

Applications are reviewed 3 times/year. Due dates are July 1, December 1, and April 1.
Please allow 90 days to receive a response.

Date

Legal Name of Applicant:

Address:

Contact Person Name and Title:

Phone:

Email:

Dollar Amount Requested: $

Date money is needed:

Mission of Organization:

Select all counties this grant applies to:

Adams Co ☐ N. Lancaster Co ☐

Lebanon Co ☐ York Co ☐

Other County

Project Title:

Program/Project Summary: (Describe the program or project that needs to be funded in 3 sentences or less)

NEEDS STATEMENT:
How do you know that this program is needed? (Describe any existing organizational, local, state, or national data or research that supports the need for this project) For information see the WellSpan community health link at: https://www.wellspan.org/community

PROJECT DETAILS:
In one sentence, please state what the goal of your project is (what you hope to accomplish with the proposed program/project):

Describe the activities that will take place to accomplish your grant project (please limit your response to no more than 5 pages). Include a timeline of activities (i.e. what will you do in the 1st quarter, 2nd quarter, etc of the grant year?)

Do you have experience with similar projects? ☐ Yes ☐ No If yes, please describe

What evidence, data, or research have you found that supports that the project you are proposing will address the need you have identified?

How will you measure the success of the program (how will you know if your goal has been achieved?) For example, participant surveys, test results, attendance at program, etc.

Is this a new program? ☐ Yes ☐ No
Is it an expansion of an existing program? ☐ Yes ☐ No
Describe how this project is different from your regular day-to-day operations?

PARTNERSHIPS:
With what other organizations are you partnering or do you plan to partner?

Are you collaborating with any WellSpan Health departments or programs? ☐ Yes ☐ No
If yes, please name them:

FUNDING:

PROJECT FUNDING			
Funds COMMITTED to Date From:		**Additional Funding Sought From:**	
A. Total Committed:	$ 0.00	**B. Total Additional Funds Sought:**	$ 0.00
C. Total Requested From WellSpan Community Partnership Grant:			
D. Total Project Cost: **A+B+C=D**			$ 0.00

If you are unable to raise all of the funds needed for this program, what is your alternate plan? (Will the project still proceed? How?)

How will this program be sustained in the future once grant funding is done?

GRANT REQUEST BUDGET:

What is the amount of this grant request to WellSpan Health?
(This amount should agree with the amount on page 1)

Budget Detail – please include a list of what you will use WellSpan Health community partnership grant funding for (supplies, services, equipment, printing, etc):

ITEM	EXPENSE
TOTAL	

Signature of Executive Director or his/her designee:

_____

<u>Please note:</u> By signing the application, you agree to provide a final grant report within 1 year of receipt of grant indicating progress on objectives and how the funds were spent. In addition, you agree that WellSpan Health may publicize the grant award and the results that you achieved.

The following items must be included with your request:

- ☐ IRS determination letter
- ☐ Current Board of Directors List
- ☐ Most recent financial statement (990 or audit)
- ☐ W-9

☐ If you have had a Community Partnership Grant in the past, please check the box and include a copy of your final outcomes report with this application.