**Aspirus Stevens Point Hospital Foundation**

**Grant Application & Guidelines**

**Grant Application Process**

The Aspirus Stevens Point Hospital Foundation accepts grant applicationsto support programs and services that enhance the quality of healthcare services for our community and the patients and families served by Aspirus Stevens Point Hospital. Capital grants for departments within the hospital are also considered during these grant cycles. Grant applications are reviewed by the Foundation Allocations Committee and ratified by the Foundation Board of Directors. Grant applications which seek funding for purchases, supplies or services that directly impact the hospital will be reviewed by Administration prior to the Allocations Committee’s consideration. Administration has the right to withdraw the application.

**Deadline for Application**

* **Applications are due the 1st of: October and April**. *Note: applications will not be accepted after this deadline*
* The Committee reserves the right to request an in-person presentation by the department at the Committee Meeting.
* All applications must be emailed to: hillary.shroda@aspirus.org

**Grant Eligibility**

Any department or program within the hospital is eligible to apply. **Grant applications must include a program budget or equipment quote and the department manager’s or director’s signature.**

External organizations may also be considered for funding, but must show a direct relationship between their program or service

in correlation to enhancing the healthcare of the patients and families served by Aspirus Stevens Point Hospital.

**Grant Criteria**

**Funded projects will:**

* Support the Mission of Aspirus Health to heal people, promote health and strengthen communities.
* Advance and strengthen the quality of healthcare services for patients and families using innovative approaches
* Demonstrate reasonable and measurable outcomes that have a long-term impact
* Support programs that are essential to the provision of high-quality services

**Aspirus Stevens Point Hospital Foundation generally does not fund:**

* Financial support to individuals
* Contributions to annual fund drives, endowment funds or capital campaigns outside of Aspirus Health
* Sponsorships, Special Events or Sporting Events

**Types of Grants Funded**

* **Program Grants** support new programs or expansion of existing programs that impact the patients and families

served by Aspirus Stevens Point Hospital

* **Capital Grants** support the remodeling of spaces or purchase of equipment for departments within Aspirus Stevens Point Hospital

**Notification of Approval/Denial**

Applicants are contacted approximately six weeks after the deadline. When final approval is given from the Foundation Board

of Directors, recipients are notified of approval or denial of their grant request. Recipients of grant dollars have one year to

utilize the funds unless other alternative arrangements have been agreed by the grantor and grantee.

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| **Contact Information** |
| **Name and title of applicant:** |  |
| **Organization/Company and Address:** |  |
| **Aspirus Department/Business Unit/Facility:****(if applicable):** |  |
| **Preferred Phone:** |  |
| **Preferred Email:** |  |

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| **Program/Capital Information** |
| My Request is a (please check appropriate selection): **◻️ Program Request**  **◻️ Capital Request**  |
| **Program/Capital Name:** |
| **Brief Summary: (one to two sentences)** |
| **Requested Amount:** |
| **Who will be served by this grant?** |
| **How many people annually will be served by this grant?** |
| **Have you received funding from Aspirus Stevens Point Hospital Foundation in the past?** **◻️ Yes ◻️ No**  **\*\* *If yes, please list project name and funded amount.*** |

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| **For Aspirus Applicants Only: Manager or Director’s Approval is Required**  |
| **Was this program or capital purchase denied during the Fiscal Budget Process?** **◻️ Yes ◻️ No** **Is there a gap in funding this project in your department? ◻️ Yes ◻️ No** **If the Foundation does not fund this project, where will funding be sought?** **Additional Leader Comments:** **Director’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Director’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Needs Assessment:**  |
| Describe how you determined a need for this project/service. What issues will be addressed? What significant long-term impact will result if funding of this grant is approved? How does it align with Aspirus and its mission? Is this project supported by colleagues within Aspirus? |
| **Information about Your Program or Capital Grant Request** |
| **Project Goal:** *(Example: Provide access to appropriate exercise equipment for patients to use when insurance no longer covers medical rehabilitation.)* |
| **Objective:***(Example: 65 people will participate in a minimum of one class per week.)* |
| **Expected Outcome(s):***(Example: 85% of participants will report feeling healthier and have a sense of independence because of their involvement in the program.)* |
| **Evaluation:** *(Example: Participation is monitored by attendance records in which rehab patients complete pre- and post-surveys to measure success.)* |
| **Return on Investment: Will use of this equipment/program be charged back to the patient?***(Please provide explanation and cost per patient, if possible.)* |

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| **Project Request: Additional Funding Sources** |

List any other funding sources sought for this proposal, the amount requested and if funding was awarded.

 If additional space is needed, please attach a separate sheet.

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|  | **Source 1** | **Source 2** | **Source 3** |
| Organization/Company: |  |  |  |
| Amount Requested: |  |  |  |
| **Project Goal:** (Yes / No / Pending) |  |  |  |

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| **Project Request: Resources Overview****\*\*\*\* PLEASE INCLUDE AN ITEMIZED BUDGET OF THE REQUESTED EXPENDITURE AMOUNT. \*\*\*\*** |
| **What resources are in place to complete or fulfill your grant request? Are other departments or organizations collaborating on the project/program? If so, please provide details.** |
| **Is this a one-time request, or will this require ongoing support of the Foundation? What amount is anticipated for future requests?** |

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| **For CAPITAL PURCHASE ONLY:** **\*\*\*\* PLEASE INCLUDE A QUOTE FROM AN ASCENSION CONTRACTED VENDOR. \*\*\*\*** |
| Please check all that apply:**◻️ This equipment was budgeted but denied during the fiscal year budget process.** |
| **◻️ This grant is requesting a new piece of equipment. Explain the benefits of the new equipment:** |
| **◻️ This grant will replace current equipment. Explain the reason for replacing:** |
| **◻️ This grant was unanticipated/not budgeted. Please explain why:** |
| **◻️ Does this equipment transmit any data?**  If yes, have you secured IT review and/or approval? (Required prior to submitting your application.) |

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| **For CAPITAL Grant Requests** |
| **SITUATION:** Explain the issue or problem at hand that you are trying to solve or improve. |
| **BACKGROUND:** Provide information such as data/statistics to validate that this situation exists. Include historical information regarding other attempts to improve or solve the situation; or other improvements that have been made that led to this situation. |
| **ASSESSMENT:** Provide information about the process used to determine a solution or different options that you’ve considered. Describe your proposed solution and how it will improve the situation. What steps or processes do you anticipate need to be completed to achieve these results? Are there additional costs in implementing the solution? |
| **RECOMMENDATION:**  Can you outline your action plan and provide the timeline to implement your recommendation?  |

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| **Applicant’s Agreement and Signature:** |

*As a condition of a grant, appropriate recognition must be given to Aspirus Stevens Point Hospital Foundation in publications and public announcements. The Foundation can assist by providing a camera-ready logo and/or reviewing press releases.*

 **By signing below, you agree:**

**◻️ The grant is consistent with Aspirus Health’s mission and values.**

**◻️ The approved grant will only be used for the specified purposes defined.**

**◻️ As steward/manager of the grant funds, I accept responsibility to initiate the grant in a timely manner. I understand that**

 **future grants will be ineligible for review if I do not comply as instructed.**

**◻️ Grants awarded for $5,000 or more will require a Funding Analysis Summary to be returned to the Foundation.**

 **Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**