Community Health Improvement
Health Partner Funding Application Cover Sheet

Name of Organization:_______________

Address:_______________

City:_______________ State:__________ ZIP: __________

Contact Name:_______________ Position: _______________

Phone Number:__________ Fax:__________ E-mail: __________

If you have someone affiliated with Parkview that serves as a Board Member or Volunteer for your organization, please list their name(s). _______________

Has your organization received previous funding from Parkview? ❑ Yes ❑ No

Priority Funding Areas (please check all that apply):

- ❑ Access to Health Care
- ❑ Disease Management
- ❑ Health Innovation and Research
- ❑ Health Screening/Prevention

Current Health Initiatives:

- ❑ Access to Health Care
- ❑ Health and Wellness for Children and Families

Amount of Request:

- ❑ Cash Donation Total Amount Requested: $__________
  (Includes program and sponsorship support)
- ❑ In-Kind Donation Estimated Value: $__________

Deadline for Health Partner Funding Application: **September 1**

(Notification provided within 120 days of application deadline.)

Specific Purpose of Health Partner Funding:

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Signature:_______________ Title:__________ Date: __________

Printed Name:_______________

Questions for Parkview Hospital should be directed to Jill McAllister at 260-373-7982 or jill.mcallister@parkview.com.
Questions for community hospitals should be directed to Tai Felger at 260-373-7972 or tai.felger@parkview.com.

All application narratives should be typed, not to exceed 5 pages. Include the following information:

Cover Letter – signed by the executive director or other officer of the organization.

Application Narrative

Provide a brief overview of the organization – include the date the organization was established, the organization's mission, geographic area served, primary programs of the organization, how your organization is unique compared to other organizations, and the number of staff and volunteers.

Give a concise overview of the program – summarize the purpose and community need for the program/project, how the funds or support will be used, how the program/project will be sustained in future years and provide the type of population and geographic area served by the program/project. Please specify whether funding requested is for a new program/project, or expansion of an existing program/project and disclose any collaborative relationships with other organizations.

Indicate how this request relates to Parkview Health's mission – as a regional health care provider, Parkview Health's mission is to provide quality health services to all who entrust their care to us, and we will work to improve the health of our communities. How would funding this program/project further Parkview Health's mission? What kind of an impact does this request have on Parkview's mission priority funding area(s) and local health initiatives? How would Parkview be acknowledged as a donor?

Describe the specific qualitative and quantitative measurable objectives – provide a narrative regarding program/project objectives, goals, plus the timeline, methods and strategies that will be used to achieve the objectives, and previous outcomes if applicable. Include how the effectiveness of the program will be determined and number of persons to be served. Also, include a completed Community Health Improvement Progress Report form (see below).

Attached Documents

Audited financial statements – provide a copy of the audited financial statements (or unaudited if the organization does not engage in an audit) for the organization's most recent fiscal year.

Operating budget for the organization – provide a copy of the organization's current operating budget. Include a breakdown of revenue sources with a detailed listing of Federal, State, and Local Government funding, and other foundation support.

Program/Project Budget – include revenue sources and detailed expenses. Indicate other sources of support for the program including amounts already received or pending.

Program Staff Information – indicate staff qualifications and number of staff involved in the program.

List of Governing Body/Board with Affiliations

IRS documentation of current tax exempt status

Completed Progress Report form

Please provide 1 original and 1 copy of the application by mail or hand delivery as follows:

Mailing Address: Parkview Community Health
Improvement Program
2200 Randallia Drive
Fort Wayne, IN 46805

By Hand: Parkview Community Health
Improvement Program
2120 Carew Street
Fort Wayne, IN 46805