Osceola Community Health FOUNDATION

OCHF Internal Grant Application

This grant application is for Osceola Medical Center's <u>department requests only</u>. It is required that all grants requests are cleared with your manager prior to completing the application. ***The foundation supports work that directly affects patients. Please do not apply for funding for items that is normally covered by operations or your department budget. For programmatic support, please be sure to address sustainability in your request narrative.***

Date of application:	**Amount of Request:**

Osceola Medical Center Department Information

Department Name:	**Director/Manager Signature:**	**Date:**
Contact Person for Application:	**Title**:	**Phone #**
	Email:	

Project Information

PROJECT SUMMARY OF REQUEST: **(**Describe your project/program/equipment briefly in 300 words or less.

CEO and/or OCHF Director Approval: _____ Date: _____

Request Narrative

Evidence of Need (Demonstrate why this is important. Is there a challenge? Are patients being affected in a negative way?)
What do you hope to achieve in accordance with OMC's mission? (What is your strategy? If applicable, describe any unique features/services of this project/program/equipment.)
What kind of impact with this program/project/equipment make? (Who or What will change? How will improve health and wellness?)
Project Dates/Timelines: (Activities: What will you do and when will you do it? Who will do it?)
How will you evaluate the success of this program/project/equipment and how will you sustain it?

Enclosures

Please enclose the following Project Expenses. Use totals in this form and attach a detailed list of expenses for the project which reflect the totals in this form. You may scan and send it along with this application to Jill Leahy at jill.leahy@myomc.org .

Equipment	
Program Materials (manuals/brochures/outreach materials)	
Supplies	
Training	
Other (Please describe)	