Ascension
All Saints Hospital
Foundation

Please return completed form to:
Ascension All Saints Foundation
c/o Carolyn Hutchinson
3805-B Spring Street—Suite 220
Racine, WI 53405, 262-687-8654
carolyn.hutchinson@ascension.org
Date _____

*Only **complete** applications will be considered.*
Applications reviewed monthly.

Patient-Associate Experience Grant Application

Project Name _____ Amt. Requested (excludes tax, max $5,000) $ _____

Applicant's Name _____ Dept. #/Acct. # _____

Email Address _____ Phone _____

Briefly describe your idea for improvement _____

_____

_____

How will this improvement impact patient—associate experience _____

_____

_____

Items needed with attached budget, formal quote, or proof of cost _____

_____

_____

Has this item already been purchased or budgeted? _____ Date _____

Ideal timeline _____

Applicant's Signature _____ Date _____

Department Head's Signature _____ Date _____

***If disbursement is granted, recognition of the All Saints Foundation on any publicity, signage, etc. is required.

FOR COMMITTEE USE ONLY

Grant Committee Action _____ Date _____

Applicant Notification _____ Date _____

Fund Disbursement _____ Date _____