Grant Application & Guidelines

The Mercy Health Foundation Grants Program will fund opportunities that enhance personalized, local care for our patients, improve positive health outcomes for our community and connect value with associate work experiences.

Grant Application Process

Mercy Health Foundation accepts grant applications year round to support programs and services that enhance the quality of health care services for the patients and families served by Ascension Mercy Hospital and Ascension Medical Group. Capital grants for departments are also considered. Grant applications need to be received by the **15th of each month**. Each grant application will be reviewed by the Fox Valley Chief Philanthropy Officer, Fox Valley Capital Review Committee, Fox Valley Business Development and Growth Council and ratified by the Mercy Health Foundation Board.

Grant Eligibility

Any department or program within Ascension Mercy Hospital or Ascension Medical Group is eligible to apply. **Grant applications must include the following to be considered for funding: program budget or equipment quote, signature of department manager, signature of senior leadership team member, SBAR for capital purchases.**

Grant Criteria

Funded projects will:

- Advance health services using innovative approaches
- Enhance quality of care and services
- Promote public awareness of health information
- Provide staff education that is necessary for the development of new or enhanced services

Types of Grants Funded

Program Grants: Program grants support new programs or expansion of existing programs that impact the patients and families served by Ascension Mercy Hospital and Ascension Medical Group.

Capital Grants: Capital grants support the remodeling of spaces and the purchase of equipment for departments within Ascension Mercy Hospital and Ascension Medical Group. ***If purchasing any equipment that transmits data, an AIS review is required PRIOR to applying***

Submission of Application

Applications are due the 15th of each month for approval by the beginning of next month. Applications can be mailed, hand delivered to the Foundation Office, or emailed to nikki.knight@ascension.org

Award Notification

Grant awards for projects under $25,000 are notified within 4 weeks of award decisions by email. Grant awards for projects over $25,000 are notified by the end of each quarter. All grantees are informed of reporting and tracking expectations with notice of funding. Recipients of grant dollars have **one year to utilize the funds**. If making a capital purchase, you will be required to use a contracted Ascension vendor and alert the foundation when equipment is delivered to the unit.

Application Cover Page

Contact Information

Name and Title of Applicant:

Date of Application:

Ascension Department: **Business Unit/Facility:**

Preferred Phone: **Preferred e-mail:**

Program/Capital Information

Program/Capital Project Name: **Requested Amount:**

Brief Summary (one to two sentences):

Cost center expenses will be charged to:

Who will be served by this grant?:

How many annually will be served?:

Approval – Department Director and Senior Leadership Team Member

Was this program or capital purchase denied during the Fiscal Budget Process? ____Yes____No

If the Foundation does not fund this project, where will funding be sought?

Director's Name:

Signature / Date: _____

Senior Leader Name:

Signature / Date: _____

Additional leader comments:

Project Information

Needs Assessment

In 500 characters or less, describe how you determined a need for the project/service and the issues that will be addressed. Explain the alignment of program design/equipment purchase to strategic plans and improved patient experience.

Project Goal, Objectives, and Expected Outcomes

Use the space below to outline project goals, specific objectives and expected outcomes. See examples listed for guidance. How will you plan to evaluate and track these outcomes?

Program Goal(s):
Ex. Provide access to appropriate exercise equipment when the medical rehabilitation covered by insurance ends.

Objective(s):
Ex. 65 participants will participate in a minimum of 1 class per week.

Expected Outcome(s):
Ex. 85% of participants will report feeling better and enjoying a sense of independence in their lives because of their involvement in the programs.

Evaluation:
Ex. Attendance records will be kept to monitor participation. Rehab patients will complete pre- and post-surveys to measure their sense of independence.

Resources Overview

What resources are in place to complete/fulfill your project/program? Are there other departments or organizations collaborating on this project/program? If so, please provide details of that collaboration (finance, AIS assessment, etc.)

Will this be a one-time request, or will this require ongoing support from the foundation? If ongoing, describe the amount of support anticipated in the future.

Return on Investment

Will the use of this equipment or program be charged back to the patient? If yes, please provide an explanation below, including cost per patient.

Ex. Yes. Services will be billed as part of Therapeutic Exercise billing code 97110. 12 patients per week x 52 weeks = 624 patients a year. 624 patients a year x 1 unit/patient ($86 per unit) = $53,664 return in one year.

Project Budget/Quote - Your request will not be considered without this information

***Program grants*: Attach an itemized budget of the requested expenditure amount.**

***Capital grants*: Attach a quote from a contracted vendor. Check all that apply and offer an explanation below.**

□ This request is for a new piece of equipment.
□ This request will replace a current piece of equipment.
□ This equipment was budgeted but denied during the fiscal budget process.
□ This equipment was unanticipated/not budgeted.

Explanation:

Applicant's Agreement and Signature

By signing below, you agree:
□ the grant is consistent with Ascension Health System's mission and values
□ the approved grant will only be used for the specific purposes defined
□ to accept responsibility to initiate the grant in a timely manner, update grant progress monthly and complete the annual Grantee Report.

As a condition of a grant, appropriate recognition must be given to the Mercy Health Foundation in publications and public announcements (i.e. Communication Boards, staff huddles, department signage). The Foundation can assist in this regard by providing a camera-ready logo, and by reviewing press releases or other printed materials.

Please be advised the foundation is required by law to provide documentation that the funds you were granted were used for the intended charitable purposes.

Applicant's Name:

Signature / Date: _____

Capital Item Assurances

If your project requires a capital purchase (equipment purchases over $5,000), please include an SBAR listed on the next page of the application.

Capital Purchase Information

Is the quote provided from an Ascension approved vendor? ____Yes ____No

Does the equipment transmit any data? ____Yes ____No

If so, have you secured an AIS review and/or approval? ____Yes ____No
****required prior to submitting an application****

Submit completed Grant Application to:
| Nikki Knight | nikki.knight@ascension.org | ph. 920.223.0520

Capital Grant Information

Grant Request SBAR - Required for capital items over $5,000

Use information from grant application to support position. Be concise and to the point.

Situation: (Refer to description of Project/Program)

Describe the issue/problem at hand that you are trying to solve/improve.

Background:

Provide background information; include data/statistics, if possible that validate that the situation exists. Also provide any historical information regarding other attempts to improve/solve the situation or other improvements that have been made that led to the situation.

Assessment: (Refer to grant's goals & outcomes & how will be measured)

Provide information about the process used to determine a solution to the situation, including the different options that were considered. Describe the proposed solution and how it will improve the situation. Include the process and/or steps that need to be completed to make the improvement and the results that can be expected. Include any costs that would be associated with implementing the solution.

Recommendation:

Provide your recommendation and the reason for making this choice. If possible, outline the action plan/timeline needed to implement the recommendation.