VERNON MEMORIAL HEALTHCARE, INC.
APPLICATION for CHARITABLE CONTRIBUTION

Applicants eligible for consideration are limited to non-profit organizations holding an active 501(c)3 status with the Internal Revenue Service. All such organizations must set forward a purpose that is consistent with the VMH mission, VMH vision and values, and be seeking funding for a purpose that aligns with the Community Health Needs Assessment for the communities served by VMH.

Part 1 – General Information			
Date:		Amount Of Request: $	
Legal Name of Organization:			
Address:			
Website:			
Is Organization U.S. Based? ☐ Yes ☐ No		What Wisconsin Counties Do You Serve?	
Contact Name:		Title:	
Phone Number:		Email:	

Part 2 – Background Questions	
1. In the most recent five calendar years, has the applicant submitted an application for a charitable contribution to Vernon Memorial Healthcare or any of its affiliates or subsidiary locations?	☐ Yes ☐ No
If yes to #1, when was the request made? _____ What funding did you receive? _____	
2. Is the applicant a licensed healthcare provider or does the applicant directly bill any federal healthcare program, including, but not limited to, the Medicare, Medicaid, and/or CHAMPUS programs?	☐ Yes ☐ No
If yes to #2, please explain: _____ _____ _____	
3. Is the applicant designated as a 501(c)3 entity by the Internal Revenue Service? (Please include a copy of your determination status.)	☐ Yes ☐ No

4. Are you aware of any Vernon Memorial Healthcare associate that is active within or in support of your organization? ☐ Yes ☐ No

If yes to #4, what is/are their name(s) and what role do they play in your organization?

_____

_____

Part 3 – Intended Use of Award if Granted

5. Provide a detailed description of how a charitable contribution by Vernon Memorial Healthcare will be used and how such use corresponds to Vernon Memorial Healthcare's mission, vision & values, and/or helps address a community health need. (Attach additional detail as necessary.)

6. Date Funds Needed:

Part 4 - Certification

By signing below, the Applicant certifies that they are an authorized agent or representative of the Applicant and has read and understands the above provisions. Applicant acknowledges that any charitable contribution awarded by Vernon Memorial Healthcare is contingent upon the completeness and accuracy of the above representations. The Applicant understands and agrees that this application does not constitute a commitment by Vernon Memorial Healthcare to award a charitable contribution even if all criteria are met and understands that Vernon Memorial Healthcare reserves the right to change the pledged amount, or to discontinue the charitable contribution, at any time.

Signature of Applicant: _____

Name and Title (Print): _____

Date Signed: _____

FOR VERNON MEMORIAL HEALTHCARE USE ONLY			
☐ **APPROVED** ☐ **NOT APPROVED**	**AMOUNT FUNDED OR IN-KIND CONTRIBUTION**		
DATE OF DETERMINATION		**AUTHORIZING EMPLOYEE**	