Riverview Foundation

ASPIRUS™

MAKING A HOSPITAL GRANT REQUEST

Riverview Health Care Foundation was created by Riverview Hospital Association in December 1984. In 2015 the Riverview Health Care Foundation became the Aspirus Riverview Foundation as a result of the Riverview Hospital affiliation with Aspirus. The primary beneficiary of funds is the Aspirus Riverview Hospital Association, however the Articles of Incorporation also state that the Foundation may make grants to non-profit tax exempt organizations in Wood County for health-related programs and projects.

The following Hospital Grant Request form must be submitted to the Foundation office no less than two weeks prior to a Board of Directors grant meeting in order for the Board to review the request. Foundation Board members are scheduled to meet the 2nd Tuesday in February, May, August, and November to review grant requests.

A spokesperson of the requesting group will be asked to attend the Foundation Board meeting to answer questions of the directors regarding the request.

Along with the following Hospital Grant Request form, please include the information below:

- ***Relevant financial information (i.e. detailed breakdown of projected expenses, price quotes, etc.)***
- ***Any other information you feel the board should know about your project.***

You will be informed of the disposition of your request within one week of the board meeting.

If you have any questions, please call Aspirus Riverview Foundation at 715-421-7488.

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HOSPITAL GRANT REQUEST

- **Name of person (employee) making request:_____**
- **Department/Program:_____**
- **Intent of funds:_____**
- **Amount of request:_____**
- **What % of total program cost is this request:_____**
- **Describe the use of the requested funds:_____**

  _____

  _____

- **Will request cover salaries? YES_____ NO_____**
- **If yes, how much?_____**
- **Has alternate hospital funding been sought? YES_____ NO_____**
- **If so, with whom?_____**
- **If denied, why?_____**
- **Would you anticipate making subsequent requests from this Foundation for this program/project/equipment?**

  YES _____(Subsequent requests likely) NO____(One-time request)

- **Further information:_____**

  _____

  _____

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TO BE COMPLETED BY EMPLOYEE'S IMMEDIATE SUPERVISOR

- **Name of Employee's Supervisor:_____**
  (Person completing this section)

- **Reason why this request was not approved by you as a hospital endeavor:_____**

  _____

  _____

- **Does this request meet the Foundation's criteria of:**

  A. It is a request that will not be funded through the hospital: YES____NO____
  B. This will be the only request for funding? YES____ NO____
  Comments if necessary:_____

  _____

  _____

  DEPARTMENT HEAD APPROVAL:

  _____DATE_____

  ADMINISTRATIVE APPROVAL:

  _____DATE_____

  DISPOSITION OF REQUEST:

  _____Presented to Hospital Board of Directors on (date)_____

  _____Sent to Foundation Office on (date)_____

  _____Presented to Foundation Board of Directors on (date)_____

  _____Approved on (date)_____

  _____Denied on (date)_____

  _____Decision communicated to person submitting request on _____

  One copy to person requesting/One copy to supervisor/One copy to Foundation