BAY MEDICAL FOUNDATION

McLaren Bay Region and McLaren Bay Special Care
Grant Request Application

All applications must include a photo of the item and a CURRENT quote from the Purchasing Department.

Incomplete grant applications will not be considered. All applications must be typed.

Grant requests are due to the McLaren Bay Medical Foundation by the 1st of January, April, July, and October.

Grant applications are reviewed by the MBR Senior Leaders prior to the Foundation Grant Committee meeting. Please forward your application and required information to Samantha.Mitchell@mclaren.org by the required deadline. You may contact Judy Dallas (989) 895-4725 or Sami Mitchell (989) 894-3837 with any questions or concerns.

Employee Name: ____________________ Signature: ____________________

Manager Name: ____

Department: ____________________ Phone Number: ____________________

Purpose of Grant (1-2 Sentences):

Total Cost **(Please attached required photo and Purchasing Department quote):** $ ____________________

***If grant is approved by the McLaren Bay Medical Foundation, all purchases must be placed within 90 days of receiving grant approval letter.**

Manager/Director Signature: ____________________ Date: ____________________

Vice President's Signature: ____________________ Date: ____________________

MBR CEO/CFO Signature: ____________________ Date: ____________________

You must have BOTH your manager and VP's signature prior to submission.

---------- **FOR FOUNDATION USE ONLY** ----------

Grant Approved: ___ Yes ___No Approval or Denial Date: ____________________

Reason for Denial: ____

Distribution Fund: ____

Restricted ☐ **Non-Restricted** ☐

1. Please explain why you are requesting this grant, what need is being addressed, what outcomes you hope to achieve and how you will spend the funds if the grant is approved.

2. Is this item patient related? If so, how many patients, in a calendar year, will utilize this item? (Patient volume does not give priority for approval)

3. Do you already have this piece of equipment in the Department? If so, how many? What is its current condition?

4. What is the long-term impact of this item? How will your job and/or patient care be affected if the grant is not approved? Please be specific.