**Grant Application 2023-2024**

**PLEASE READ THE GRANT GUIDELINES BEFORE COMPLETING THIS**

**APPLICATION FORM.**

**The deadlines for grant applications for fiscal year 2023-2024 are:**

1. **October 13, 2023** for the November 2023 meeting (decisions communicated in December)
2. **April 12, 2024** for the May 2024 meeting (decisions communicated in June)

**Please submit your application electronically, as a single PDF file, to** **overlookgrants@atlantichealth.org**

***Please limit the PDF file size to 3MB.***

**Organization**

Legal name:

Address:

City:       State: NJ Zip:

Federal Tax ID#:

Website URL:

Organization Mission Statement:

Program Name:

Category:

Existing Program [ ]  Equipment [ ]  New Initiative [ ]  Other [ ]  Please specify:

In 50 words or less, summarize the program for which you are seeking support.

Amount of the grant you are seeking: $      **($10,000 maximum grant request)**

Provide a more detailed description of the program you are requesting Overlook Foundation to support. Please include information on:

* Needs to be addressed and how the program will operate.
* The projected outcome or results of the program and how the outcome will be evaluated.

**Population served**

Total number of people expected to be served by the program.

The primary service area for Overlook Medical Center includes:

1. Union County (all municipalities)
2. Essex County (Maplewood; Millburn/Short Hills; Newark; Irvington; West Orange)
3. Somerset County (Warren; Watchung; Basking Ridge)
4. Middlesex County (Dunellen; Piscataway)
5. Hudson County (Bayonne)
6. Morris County (Chatham; Morristown)
7. Other bordering towns on a case-by-case basis

Please describe how the program/project will impact the primary service area for Overlook Medical Center.

**Person responsible for program oversight and evaluation**

Name:       Title:       Date:

Address (if different from the organization):

Phone:       Email:

**Person submitting this application**

Name:       Title:       Date:

Address (if different from the organization):

Phone:       Email:

* [ ]  **Overlook is a member of the Atlantic Health System (AHS), an integrated health care network committed to the highest standards of diversity and inclusion. Our diversity and inclusion statement may be found on the** [**AHS website**](https://www.atlantichealth.org/about-us/who-we-are/diversity-inclusion.html)**. In submitting this application, I certify that that my organization is committed to diversity and inclusion, and shares in the values established by AHS.**
* [ ]  **In submitting this application, I certify that the information I have provided is accurate and complete to the best of my knowledge and that I have full authorization to submit this application of behalf of the organization.**

**Budget and other information**

***Please use this form to present a detailed budget.***

What is the proposed time frame for this program?

Describe your plan for the program to be self-sustaining in the future.

PROJECT BUDGET

|  |  |  |  |
| --- | --- | --- | --- |
| **PROJECT EXPENSES** | **Overlook Foundation****(as requested in this application)** | **FROM OTHER SOURCES** | **TOTAL** |
| Personnel/staffing(Please specify)       |       |       |       |
| Contracted services(Please specify)       |       |       |       |
| Consumable supplies(Please specify)       |       |       |       |
| Durable supplies & equipment(Please specify)       |       |       |       |
| Support/training(Please specify)       |       |       |       |
| Other costs(Please specify)       |       |       |       |
| **TOTAL DIRECT COSTS** |       |       |       |
| Any overhead or indirect costs attributed to this project (Please specify) |       |       |       |
| **TOTAL EXPENSES** |       |       |       |

|  |
| --- |
| **Please show source(s) and amount(s) already approved listed in the From Other Sources column above** |
| **Source of approved funding** | **Amount** |
|       |       |
|       |       |
|       |       |
|       |       |