



Independence Blue Cross Charitable Medical Care Grant Program

The Independence Blue Cross Charitable Medical Care Grant Program provides financial support for non-profit, privately funded clinics in southeastern Pennsylvania providing free or nominal fee care to the uninsured.

This three-year commitment makes grants available to support areas such as general operating expenses, unfunded pharmaceutical needs, medical supplies, specialty care, diagnostic tests, or other pertinent needs critical to the delivery of service.

The need for requested funding must be clearly demonstrated in the application. IBC will gladly consider multi-year grant requests. However, awards of multi-year grants will be disbursed annually and only after a satisfactory review of required reporting.

Grant requests are reviewed by the IBC Charitable Medical Care Grant Committee. Organizations are strongly urged to apply for funding as soon as possible.

For more information, contact social.mission@ibx.com or call (215) 241-3229.

Please mail completed applications to:

**Sheila M. Hess
Manager Social Mission Programs
Independence Blue Cross
1901 Market St., 29th floor
Philadelphia, PA 19103**

www.ibx.com

CHARITABLE MEDICAL CARE GRANT PROGRAM

Grant Application Narrative

Please provide the following information **in this order**. Do not use more than 5 pages, exclusive of attachments.

Organizational Information

1. Brief Summary of Organization's history and mission.
2. Description of current programs, activities, service delivery model, key affiliations with hospitals and other health care providers, service statistics and strengths/accomplishments (highlighting the past year), including what makes your organization unique.

I. Financial Information

- For **ALL grants**, please submit the following information:
 - Organization's annual operating budget and actual income and expenses for most recently completed fiscal year **AND** for current year-to-date.
 - Itemized budget for how this specific grant will be used. Identify each source of revenue, the amount, and whether funds are either committed or pending. If request is for a multi-year grant, include multi-year program budget.
 - Organization's most recent **AUDITED** financial statement (if budget greater than \$100,000) or Form 990 (if budget between \$25,000 and \$100,000). If neither document is available, include unaudited financial statements.
 - Organization's three (3) largest funders in the last fiscal year and type of grant.

II. Other Supporting Materials

- Latest annual report or summary of the organization's prior year activities.
- Current board list with members' employment affiliations, constituencies, and years served.
- An organizational chart (if applicable) and a one paragraph description of key staff.
- Letters of agreement from any collaborating or affiliated agencies, if applicable.
- Letters of support and/or recent reviews or articles, if available.

III. Purpose of Grant

The situation—opportunity, problem, issue, need, and the community—that your proposal addresses, and how that need was determined.

- **Goals and Activities**
 - Your goals and objectives.
 - Specific, measurable activities to accomplish these objectives.
 - Who will carry out those activities (if this is a collaboration, briefly describe the partners).
- **Impact of Activities**
 - How the proposed activities will impact the designated community or population.
 - How you will measure the results, and how results will be used, disseminated, or publicized.
 - How you plan to sustain the clinic or program after the funding period has expired.



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Grant Application Cover Summary

1. **Legal Name of Organization:** _____

Address, Telephone and Fax: _____

Email address: _____

Web address (if applicable): _____

Name and title of contact person: _____

Name of Executive Director: _____

Name of President of Board: _____

Federal ID number: _____

2. **IRS 501c(3) nonprofit?** **YES** **NO**

If **Yes**, please attach copy of designation letter from IRS.

3. **Amount Requested:** \$ _____

4. **Total number of Board Members:** _____

5. **Type of Grant Requested** (Operating, Program, Other): _____

6. **State Your Organization's Mission:**

7. **Summarize the proposal**, including the name of the program, if applicable:

8. **List the Proposal's Target Population, Constituents, and Geographic Communities:**

9. Total annual organizational budget: \$ _____ Dates of fiscal year: _____

10. Time period this grant will cover: _____/_____/_____ to _____/_____/_____

11. Total number of Employees: Full Time _____ Part Time _____ Volunteer _____

12. Does your organization receive support from United Way or any other federated funds?

Please circle: YES NO

If Yes, percentage of total operating budget supported by these entries: _____%

13. List top 3 major funders and amount:

14. Does your organization receive government support of any kind? YES NO

15. If so, list the amount and sources:

16. Please describe the delivery model of your clinic (volunteer physician, Certified Registered Nurse Practitioner, etc.):

17. Number of Individuals served annually? _____

18. Is your clinic a participating provider with any health insurers? YES NO

If so, what Health Plans? _____

19. What percentage of those served are insured? _____

20. Does your clinic facilitate applications for clients eligible for government or private programs?
If so, please describe.

21. Signature of Executive Director: _____ DATE _____