

MISSION STATEMENT

The mission of the Ascension Saint Thomas Foundation is to advance the caring ministry and medical excellence of Ascension Saint Thomas by providing funds for research, education, and charity programs.

In carrying out its mission, the Foundation embraces the philosophy and mission of healing and service to the sick and poor, and to promote, support, and engage in any of the religious, charitable, scientific and educational ministries established by Ascension Saint Thomas.

The Foundation strives to uphold the core values of Ascension Saint Thomas, using these values as our guiding principles in all that we do.

OUR VALUES

| | |
|----------------------------|--|
| Service of the Poor | Generosity of spirit, especially for persons most in need |
| Reverence | Respect and compassion for the dignity and diversity of life |
| Integrity | Inspiring trust through personal leadership |
| Wisdom | Integrating excellence and stewardship |
| Creativity | Courageous innovation |
| Dedication | Affirming the hope and joy of our ministry |

GRANT PROCESS AND REQUIREMENTS

- The attached form must be filled out in its entirety before submitting it to Foundation.
- The Foundation Vice President reviews requests once a month. An answer will be provided within 30 days.
- Grant requests over \$10,000 must be approved by the Foundation Grants Committee. The Grants Committee meets once a quarter. Once the request is submitted to the Foundation office, an answer will be provided within 90 days.
- Grant requests over \$50,000 must be approved by the Ascension Saint Thomas Foundation Board of Directors. The full board meets once a quarter. Once the request is submitted to the Foundation office, an answer will be provided within 90 days.

**Forms may be returned to ASTFoundation@ascension.org
or at the Foundation Office located on the campus of
Saint Thomas West Hospital.**

4220 HARDING ROAD • NASHVILLE, TENNESSEE • 37205 • 615.222.6800



SECTION I. GENERAL INFORMATION

| | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|
| Date | Campus | Bus Unit # | Dept # | Account # |
| <input type="text"/> | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Name | Department | | | |
| <input type="text"/> | <input type="text"/> | | | |
| Phone | Fax | Email | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | | |

SECTION II. GRANT INFORMATION

| | |
|----------------------|--------------------------|
| Amount Requested | Type of Request |
| <input type="text"/> | One-Time Multi-Year |
| Project Name | |
| <input type="text"/> | |
| Purpose of Grant | |
| <input type="text"/> | |

Please select one or more of Ascension’s six guiding values which this grant will address and describe how these values will be met.

Service to the Poor

Reverence

Integrity

Wisdom

Creativity

Dedication

Target Population: Who is your program or project serving?

Anticipated Results: What are the anticipated results of the program or project?

Specific Indicators: What measures will demonstrate you are accomplishing your stated goals? What are you tracking and/or measuring to let you know that the program or project is having the intended impact? Include baselines and targets.

Partnerships: Who are key program partnerships and collaborators?

Other Funding Resources: Please describe other funding resources available.

Will this require a Capital Expenditure Request (CER)? Yes No

If yes, please include name of person responsible for submitting Capital Expense Request (CER).

| | | |
|----------------------|----------------------|----------------------|
| Contact Name | Phone | Email |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

SECTION III. SIGNATURES

| | | |
|-----------------------|----------------------|----------------------|
| Department Head Name* | Signature | |
| <input type="text"/> | <input type="text"/> | |
| Date | Phone | Email |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Please approve requests that you feel will be most beneficial to your department and can ensure your funds are used in the most valuable way for Saint Thomas Health.*

Comments

SECTION IV. ADDITIONAL FILES

Please attach any additional files that will support your grant application. These items may include anticipated expense reports or budgets, diagrams, invoices, pictures, etc.

For Internal Use Only:

| | | | |
|-------------------------------|---------|----------------------|--|
| Approved by | | Date | |
| <input type="text"/> | | <input type="text"/> | |
| AST Foundation Vice President | | | |
| Fund | | Amount in Fund | |
| <input type="text"/> | | <input type="text"/> | |
| Outcome Report Needed | Yes | No | |
| Capital Expenditure Request | Yes | No | |
| Payment Method | Invoice | P-Card | |