NORTHSIDE HOSPITAL

Internal Use Only

Date approved: _____
Amount approved: $_____

APPLICATION FOR CHARITABLE CONTRIBUTION

I. ORGANIZATION CONTACT INFORMATION

Name of Organization: _____

Address: _____

City and Zip code: _____

Name of Contact Person: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Is this organization a certified 501 (c) 3 corporation or other charitable organization under the U.S. Internal Revenue Code? _____Yes. *If yes, please attach documentation showing the most recent certification.*
_____ No

*Tax letters stating the value of goods or services in exchange for a gift must be submitted to Sponsorships@northside.com or mailed to the attention of Sponsorship at Northside Hospital, 1000 Johnson Ferry Rd NE, Atlanta GA 30342 within 60 days post event.

II. EXPLAIN THE PURPOSE OF THE ORGANIZATION

Please explain the organization's purpose, and, if available, attach any relevant literature or other information about the organization.

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III. REQUESTED CONTRIBUTION

Please specify the amount of the requested contribution and/or specify the in-kind services requested.

Amount Requested:

$_____

In-Kind Services Requested:

____ Equipment
____ Supplies
____ Other: _____
____ Space
____ Hospital Personnel

IV. REASON FOR REQUEST

Please choose the activity or program category(ies) that best match your request:

____ Charity event for not-for-profit community organization
(Information regarding your event must be submitted along with this application)
____ Fund for a local community clinic
____ Emergency funds for individuals in the community
____Community building activity *(e.g., physical improvements and housing, economic development, community support, environmental improvements, coalition building, community health improvement advocacy, workforce development)*
____ Non-local community requesting help for response to natural disasters
____ Community health improvement services benefitting persons living in poverty
____ Subsidized health services
____ Other: _____

Describe how the donated funds will be used to address a community need and benefit the health of the community. Attach any additional information describing the activity or program that is the subject of this request. Additionally, if applicable, explain how the intended use aligns with one or more of Northside's top community needs identified in **Appendix 1**.

Explain how this request aligns with Northside's mission set forth on **Appendix 1** to this Application.

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V. ATTESTATION AND STATEMENT OF UNDERSTANDING

I _____ attest that the information in this application and its attachments is true and accurate and that this request is not made for the purpose of influencing any governmental or legislative decision or for any unlawful purpose. Additionally, on behalf of _____, I understand that any funds awarded to the organization must be used to directly fund/support the activity stated in Section IV above.

By: _____ Date: _____

APPENDIX 1

NORTHSIDE'S IDENTIFIED COMMUNITY NEEDS

Northside has identified the following as the top community needs:

Fiscal Years 2022 – 2024
Cancer
Cardiovascular
Maternal & Infant Health
Behavioral Health & Substance Use Disorder
Diabetes & Obesity
Access to Care
Healthy Lifestyle Behaviors
Respiratory Disease & Smoking
HIV/AIDS

NORTHSIDE'S MISSION

Northside Hospital is committed to the health and wellness of our community. As such, we dedicate ourselves to being a center of excellence in providing high-quality health care. We pledge compassionate support, personal guidance and uncompromising standards to our patients in their journeys toward health of body and mind. To ensure innovative and unsurpassed care for our patients, we are dedicated to maintaining our position as regional leaders in select medical specialties. And to enhance the wellness of our community, we commit ourselves to providing a diverse array of educational and outreach programs.