VOLUNTEER COUNCIL
GRANT APPLICATION

Funding will support the Patient & Family Centered Care approach to health care as outlined in "Carolina Care."

Date:	Name:
Email:	Title & Department:

Please check all that apply to this grant:

___Patient/Family Need ___Staff Support ___Community Service ___Education

Please provide the following information (attach additional pages if necessary):

1. Brief description of project:

2. Statement of need/problem to be addressed:

3. Description of how this funding will support Patient & Family Centered Care:

4. Clear description of program goals and measurable objectives:

Units Needed: ____ Cost/Unit: _____ Total Cost (including freight):_____

Signature of Requestor:

Signature of Supervisor:

(Electronic Signatures Accepted)

For grants over $500.00, please attach estimates from vendors
A follow-up report (Form G-5) is required within 90 days of completion of the project.