MISSISSIPPI HEALTH CARE FOUNDATION

MAKE-A-MEMORY

GRANT APPLICATION

This form is to be used with the grant application information sheet when submitting a request to the Make-a-Memory Program. This request can be for an individual or a group of residents at one (1) or more Mississippi licensed skilled nursing facilities. Please answer each question with as much detail as possible. If additional space is needed, please use additional pages, noting to which question or section the extended answer belongs.

Resident Name*:_____

Resident Age*: _____ Resident Gender: _____

*If submitting a request for a group of residents give an overview of the group.

Facility: _____

Facility Mailing Address: _____

Facility City/State/Zip: _____

Facility Phone Number: _____ Facility Fax Number: _____

This application must have the signature of the Facility Administrator and at least one (1) other facility staff member (must be Social Work Director, Activity Director, or Director of Nursing or other appropriate staff).

Administrator's Signature: _____

Secondary Signature & Title: _____

On facility letter head, attach a 250-word minimum typed narrative with information requested on grant application information sheet. **Mail or email to:**

Mississippi Health Care Foundation
303 Brame Road
Ridgeland, MS 39157
foundation@mshca.com

For Foundation Office Use Only

_____ Date Received	_____ Date Reviewed	A B C Circle Review Method
_____ Approved	_____ Not Approved	Approved $_____
_____ Notification Sent	_____ Check Sent	Check #_____

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GRANT APPLICATION

I. Complete Grant Application form.

II. On facility letterhead, attach to the Grant Application form a minimum 250-word typed narrative, which includes:

- Describe the Make-a-Memory request in detail.
- Describe why the resident wants this Make-a-Memory granted.
- Give background on the resident as related to this request (include brief family history, age, health, physical limitations, etc.). Include a release signed by the resident or his/her representative that authorizes the release of this information.
- Explain why the request is being made to MHCF.
- Describe resources at your facility to help make the memory a reality and/or what your facility will be contributing to help fulfill this request.
- Suggest how this Make-a-Memory request can become a reality.
- Estimate the cost(s) associated with this request.

Completed applications should be mailed or emailed to:

Mississippi Health Care Foundation
303 Brame Road
Ridgeland, MS 39157
foundation@mshca.com

Incomplete applications will be returned to the facility. The MCHF reserves the right to request additional documentation and/or information.

Applications received by the 10th of the month will be reviewed for notification to the facility by the 10th of the following month. Applications received after the 10th of the month will be held for the next review period. It is estimated that it will take three (3) to four (4) weeks for review and notification to the facility.

If you have questions or need additional information, please contact the MHCF at 601-898-8320.