2024

Charitable Request Application

Physician Associates of MidMichigan Community Medical Foundation

For calendar year 2024, PAMCMF will accept charitable request applications (and supporting documentation) **Jan. 1 – September 30, 2024.**

All applicable fields must be completed in full. All required supporting information and documentation must be submitted at the time of submission of this Application. Failure to complete this Application in full and submit the required supporting information and documentation will result in disqualification of the charitable request.

The Applicant is required to review the PAMCMF Charitable Giving Criteria prior to submission of this Application, and to confirm the understanding of the terms, conditions and Applicant's obligations found therein.

Applicant Demographics

APPLICANT NAME (INDIVIDUAL OR ORGANIZATION)

STREET ADDRESS | CITY | STATE | ZIP

PHONE | FAX | EMAIL

RELATIONSHIP OF PERSON COMPLETING THIS APPLICATION TO APPLICANT (Note: Applicant may be contacted to verity authority of person completing Applicaiton.)

PHONE (If different from Applicant.) | EMAIL (If different from Applicant.)

Is Applicant an eligible, non-profit charitable organization? ☐ Y ☐ N

If yes, provide copy of IRS Determination Letter of 501(c)(3) or other approved charitable status

Each Applicant is required to provide a completed and signed IRS Form W9 – is it included? ☐ Y ☐ N

Please provide a copy of IRS Form W9.

Is Applicant a 'Disqualified Person', as defined by applicable law and the rules and regulations of the Internal Revenue Service (IRS)? ☐ Y ☐ N

- See the IRS definition of *'Disqualified Person'*

If you are not sure whether the Applicant is a 'Disqualified Person' provide facts or circumstances that could make the Applicant a 'Disqualified Person.'

If Applicant is not a 'Disqualified Person,' does Applicant have any family or business relationship with any officer, director, committee member or any other employee or independent contractor of PAMCMF? ☐ Y ☐ N

If yes, describe Applicant's family and/or business relationship:

Is Applicant located within the geographic area served by Physician Associates of MidMichigan, PC (PAM)? ☐ Y ☐ N

- See the list of *areas served by PAM.*

Do any of the exclusions listed in the Exclusions and Conditions section of the *Charitable Giving Criteria* apply? ☐ Y ☐ N

Charitable Request

Aligning with PAMCMF's charitable giving philosophy, requests from Applicants meeting one or more of the criteria below are preferred:

Is the charitable request directly related to: ☐ Y ☐ N

- Health, wellness, or health education? ☐ Y ☐ N
- Access to clinical care and clinical technologies? ☐ Y ☐ N
- Enhancing health services in rural or underserved *area(s) served by PAM?* ☐ Y ☐ N
- Supporting and strengthening the delivery of health care services?

If you answered 'Y' to one or more of the above questions, provide a complete description of the charitable request, the amount of financial assistance requested, and describe how approval of the charitable request will support or achieve one or more of the above criteria.

Is the Applicant a current or recently graduated Health Profession Student? ☐ Y ☐ N

- See the *Charitable Giving Criteria* for the definition of 'Health Profession Student'

If Yes, answer the following questions and provide the required supporting documentation. If no, skip to the Additional Information Section:

1. Are you requesting an educational grant or scholarship? ☐ Y ☐ N
2. Are you requesting assistance with educational loan repayment for advanced health profession studies? ☐ Y ☐ N
3. Do you currently practice or intend to practice your profession following completion of your residency, fellowship or other educational program in an *area served by PAM* ? ☐ Y ☐ N

If you answered Yes to Questions 1 and 3, provide a complete description of your educational grant/scholarship request, a description of your area of study, supporting documentation from your educational institution confirming your active enrollment in advanced clinical education and the amount of financial assistance you are requesting.

If you answered Yes to Questions 2 and 3, provide a complete description of your educational loan repayment request, a description of your completed area of study, supporting documentation from your educational institution confirming your matriculation/graduation in a health profession field, confirmation that your health profession education has been paid in full or the amount you still owe for your education, and list the amount you are requesting for educational loan repayment assistance.

Additional Information

Provide any additional information about the Applicant and the charitable request that may be helpful to PAMCMF in making its decision on this Application.

Attestation and Agreement

I certify and confirm that (i) I am the Applicant or I have been duly authorized by the Applicant to complete this Application and provide all associated information and documents, (ii) all information and documents provided as part of this Application are accurate, complete and to the best of my knowledge, and PAMCMF may and shall treat, rely and enforce all statements made hereunder to the fullest extent permitted by law, (iii) I have reviewed the PAMCMF Charitable Giving Criteria, and fully understand the terms, conditions and the rights and remedies of PAMCMF thereunder, including the adverse consequences of failure to comply with any of the criteria and/or Applicant's obligations outlined therein, (iv) I agree (personally or on behalf of the Applicant, as applicable) to comply with the Applicant's obligations under the PAMCMF Charitable Giving Criteria, and (v) submission of this Application does not guarantee an approval of the request being made hereunder. I agree to indemnify and hold PAMCMF, its directors, officers and representatives harmless from and against any and all claims, liabilities and damages, and hereby waive any and all claims against PAMCMF, its directors, officers and representatives, in any way related to, arising out of or in connection with this Application, the Applicant's acts, omissions or violation of the applicable laws, and/or the use or misuse of any of the funds (if any) granted to the Applicant by PAMCMF as a result of this Application. To the extent permitted by law, the Applicant's acceptance of any funds from PAMCMF (if any) shall constitute the Applicant's consent and authorization for PAMCMF to use, publish and maintain the Applicant's name, likeness, photograph(s) of award ceremony and/or any and all information that Applicant at any time provides to PAMCMF, on the PAMCMF's website and/or in any of its future communications and publications, without any compensation or any prior notice or approval.

SIGNATURE OF APPLICANT / PERSON COMPLETING APPLICATION

PRINTED NAME

ORGANIZATION LEGAL NAME, IF APPLICABLE

DATE