Ascension Saint Thomas
Rutherford Foundation

Grant Request Form

Mission Statement

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

In carrying out its mission, the Foundation embraces the philosophy and mission of Ascension Health 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 which are now, or may hereafter be established by Ascension or Saint Thomas.

The Foundation strives to uphold the core values of 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 Saint Thomas Rutherford Foundation is designed to help needy patients as a resource of last resort and to support projects that fulfill our mission. Your help in vetting and supplying documentation is vital to our ability to serve the ministry. Therefore, please send any additional information such as bills and/or attachments with the request form which would assist in our approving and subsequently processing this request.

- You must complete all applicable and required sections of the attached form before submitting it to the Saint Thomas Rutherford Foundation.

Forms may be returned to:

Foundation Office
1700 Medical Center Parkway
Murfreesboro, TN 37129

Or emailed to kimberly.hopkins@ascension.org

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Grant Request Form

Date | Campus | Bus Unit | Dept | Account

Name | Department

Email | Phone | Amount Requested

*Please check either General or Patient Assistance. For patient requests, please select where the patient is in the **Needs Assessment** process.*

- ○ General
- ○ Patient Assistance
  - ○ Patient is PARO approved.
  - ○ Patient is deemed eligible for charity care.
  - ○ No other resources exist.

Description

Vendor Name | Vendor ID *(if applicable)* | Vendor Phone *(if applicable)*

Are they a Symphony vendor? ○ Yes ○ No Does vendor accept credit cards? ○ Yes ○ No

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Manager Name* | Date

Manager Signature | Email

**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 Ascension Saint Thomas.*

Comments

For Internal Use Only:

Approved by | Fund | Grant #

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