COMMUNITY BENEFITS ACTIVITY REPORT

Event Information

☐ MMC ☐ KMHC	☐ POMH ☐ North Flight	☐ Home Care/Hospice ☐ Dialysis	☐ Home Services (HME & Private Duty) ☐ Munson HealthCare Regional Foundation ☐ POMH Foundation

Title of Activity: _____ Date of Activity: _____
Sponsoring Dept: _____ Dept Number: _____
Number of Events: _____ Number of Persons Served: _____
Description/Purpose of Activity _____

_____

_____

_____

Non-Staff Direct Expenses

Direct Expenses: _____
Purchased Services: _____
Supplies: _____
Other Direct Expenses: _____

Revenue

Program fees: _____
Foundation/Fundraising: _____
Grants / Support: _____
Grant Source: _____
Other Revenue: _____

Staffing

Total hours spent on this activity: _____
Salaries: # of paid hours _____ @ Average Hourly Rate $ _____ = $ _____

Volunteers

Did non-paid community/hospital volunteers contribute time to this activity? Yes _____ No _____
Total number of hours: _____

Notes / Comments

_____

_____

Community Needs

☐ Activity Addresses an Unmet Community Need ☐ Collaborative Effort
☐ Activity is not Duplicated in the Community Partners: _____

Setting

☐ Inpatient ☐ Outpatient ☐ Facility ☐ Community
☐ Workplace ☐ Home ☐ Other: _____

Format

☐ Seminar ☐ Health Fairs ☐ Screening ☐ Speaker Bureau
☐ Event/Meeting ☐ TV/Radio ☐ Newsletter ☐ Clinic ☐ Other: _____

Target

☐ Person with Disabilities ☐ Racial, Cultural, & Ethnic Minorities ☐ Uninsured/Underinsured
☐ Other: _____

Gender: ☐ All ☐ Female ☐ Male

Age group: ☐ Infant ☐ Children ☐ Teen ☐ Adult ☐ Seniors ☐ All

Submitted by: _____ **Phone #** _____