

MEDICINE HAT CATHOLIC SCHOOLS' EDUCATION FOUNDATION

1251 1st Avenue SW Medicine Hat, AB T1A 8B4
Phone 403-502-8351 Fax 403-529-0917
www.mhcbe.ab.ca



School Project Enhancement Grant APPLICATION FORM

**ALL SECTIONS OF THE FORM MUST BE COMPLETED FOR APPLICATION TO BE CONSIDERED.
Please use additional pages where necessary.**

School _____ Contact Person _____

Name of Project _____

Project Dates From _____ To _____

Project Lead Person _____

GRANT SUMMARY - snapshot description of project:

PARTICIPANTS:

Number of students involved _____

Total # of students in school _____

Number of staff involved _____

Number of community persons involved _____

PROJECT PARTNERS:

Please list any other schools, groups or organizations that are partnering with you to implement the project.

PROJECT GOALS

Briefly describe how the grant will enhance student learning and demonstrate alignment with funding priorities.

PROJECT OBJECTIVES

What specific, measurable changes will occur as a result of your project?

What will be the direct impact of these changes on students?

PROJECT ACTIVITIES

Please describe your planned project activities.

SUCCESS INDICATORS

What information will help you determine if your project has been successful? Briefly outline the methods that will be used to evaluate the project.

SUSTAINABILITY (if applicable) and LONG TERM IMPACT

How will the project be supported after the funding period ends? What is the long term impact?

OUTCOMES AND ASSESSMENTS

How will the project be evaluated and measured for success? Who will evaluate the initiative?

How does this initiative reflect the goals of your school, your parish and your community?

BUDGET

Please provide a detailed account of how the school expects to spend the grant money. Submit additional sheet if required.

CELEBRATE SUCCESS

How will you share your story and celebrate student successes?

PREVIOUS APPLICATIONS

Has your school previously applied for the School Project Enhancement Grant? YES NO If yes, when? _____

Has your school ever been awarded the School Project Enhancement Grant? YES NO If yes, how much? _____

POST GRANT REVIEW

Schools receiving a grant from the Foundation will be requested to complete a post grant review.

Please complete Post Grant Review Form attached.

SIGNATURES

Team Lead

Date

Principal

Date

Superintendent

Date

FOUNDATION USE ONLY

Grant Application Rec'd - Date _____ Information pkg. complete Yes No

Review Committee Mtg - Date _____ Grant Application Approved Yes No

Amount Approved \$ _____ Cheque # _____ Date Paid _____

Post Grant Review Rec'd - Date _____ Information pkg. complete Yes No

Chair, Review Committee _____ (signature)

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School Project Enhancement Grant POST GRANT REVIEW

Post Grant Review must include:

- Financial Expenditure Review**
Note: money not used for the project must be returned to the Foundation

- Outcome Results** - *should include the following:*
 - Were project goals and objectives met?
 - Success indicators
 - Sustainability and long term impact of project
 - How did you celebrate success?

- Testimonials** - *include student, teacher, parent, volunteers as applicable*

- Photos** - *include pictures that tell the story, as applicable*

- FOIP forms**

Post Grant Review must be submitted by:

Date