# 2020 AHP Report on Giving:
# Mini survey
# Non-compensation Section

The following survey form represents the questions asked in the non-compensation section of the AHP Report on Giving Mini survey. The data collected will represent results from FY 2019.

Whether you're a returning from last year or have never submit data before, please sign up to let us know you'd like to participate for 2020. The survey will open on Monday, April 6th, 2020 and will close on Friday, July 3rd.

For any questions about the survey, contact us at benchmarking@ahp.org.

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*Whom should we contact if we have a question about your survey responses?

**Note:** If needed, you can list additional contacts later.

First name _____

Last name _____

Title _____

Email address _____

Phone number _____

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*Please provide the name of the philanthropic organization you are providing data for.

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*Please provide the country of the philanthropic organization you are providing data for.

Choose your country ▼

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*Please provide the city/country of the philanthropic organization you are providing data for.

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*Please provide the state of the philanthropic organization you are providing data for. **(US ONLY)**

Choose your state ▼

*Please provide the province of the philanthropic organization you are providing data for. **(CANADA ONLY)**

Choose your province ▼

What month does your fiscal year 2019 end on?

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

What year does your fiscal year 2019 end on?

- 2018
- 2019
- 2020
- 2021

*Are you reporting on a single healthcare entity or a healthcare system?

- Single healthcare entity
- Healthcare system

*Please identify the entity type for your healthcare entity. **(SINGLE HEALTHCARE ENTITY ONLY)**

- Academic medical center
- Behavioral health facility
- Children's hospital
- Community hospital
- Home care/hospice facility
- Other (please describe) _____

*Please report the total number of entities in your healthcare system and the number of each entity type for which you raise funds. **(HEALTHCARE SYSTEM ONLY)**

| | Number of entity type | Number for which funds are raised |
|---|---|---|
| Academic medical center | | |
| Behavioral health facility | | |
| Children's hospital | | |
| Community hospital | | |
| Home care/hospice facility | | |
| Other (please describe below) | | |
| TOTALS | | |

*Please report your Net Patient Service Revenue below. **(US ONLY)**

_____

*Please report your Gross Operating Revenue below. **(CANADA ONLY)**

_____

What was the total (combined) fundraising expense budget for your entity or system philanthropy operations?

_____

*Please provide your revenue information below.

- ○ Total Recorded Revenue _____
- ○ Total Production Revenue _____
- ○ Total Number of Recorded Gifts _____
- ○ Total Number of Production Gifts _____
- ○ Total Number of Donors _____

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Do you have any comments to explain your data in this section?

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*Are you completed with this section?

- ○ Yes
- ○ Not yet

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