



Grant Application Form March 2011

The *Comfort in Care* program of the Health Care Foundation has been established to generate funding for items that enhance patient comfort and wellbeing.

We are pleased to offer a total of \$20,000 in grant funding in this sixth round of grants thanks to the generosity of our corporate sponsor, **Johnson Insurance**. In addition to the \$20,000 there will be \$10,000 in grant funding awarded to enhance comfort with end of life/palliative needs. We would also like to thank all those who support the *Comfort in Care* program.

For this round only, the Health Care Foundation has received a special donation from MedSurg Solutions and Hill-rom of (1) Versacare Bed with air mattress. Please indicate on the application form if you wish to be eligible for this item, and if so, how it would benefit your unit.

To be eligible for this round of *Comfort in Care* grants, the following criteria must be met:

- The unit/area for which you seek funding must not have already received a *Comfort in Care* grant within the past 12 months. *This also includes awards of a special product donation.*
- The applicant must work within the five adult hospitals in the St. John's region.
- A maximum of \$2,500 will be awarded per grant. Items that cost more than \$2,500 will not be considered for funding unless the Program Director can provide assurances that the remaining money will be covered through other funding sources.

STAFF INFORMATION SECTION

Name: _____

Position/Title: _____

Hospital Site (please check one):

- General Hospital St. Clare's Mercy Hospital Waterford Hospital
 Dr. L.A. Miller Centre Dr. Walter Templeman Health Centre

Hospital Unit / Work Area: _____

Work Telephone: _____ **Work E-mail:** _____

GRANT REQUEST INFORMATION SECTION

COMFORT IN CARE – GENERAL (\$20,000)

Please check the applicable category for which you are requesting funding for your Unit/Area:

- Equipment**
To assist applicants with the purchase of medical equipment and/or technology that will be beneficial to patient comfort and safety that is not considered a capital equipment purchase.
- Special Projects**
To assist applicant with the completion of a project that has been approved by the management of Eastern Health that will benefit patient comfort and safety.
- Comfort Supplies**
To assist applicants with the purchase of medical supplies that would be considered beneficial to the comfort of patients. This is not meant to address individual patient needs.
- Education**
To assist applicants with furthering education on comfort and care related issues facing health care. These grants will not be issued to individuals, but will be used to provide a guest speaker and associated costs with holding a seminar or conference in St. John's to benefit many staff. The applicant must have an education session developed or a person of interest identified.

COMFORT IN CARE – PALLIATIVE (\$10,000)

Please check the applicable category for which you are requesting funding for your Unit/Area:

- Equipment**
To assist applicants with the purchase of medical equipment and/or technology that will be beneficial to patient comfort and safety at end of life that is not considered a capital equipment purchase.
- Special Projects**
To assist applicant with the completion of a project that has been approved by the management of Eastern Health that will benefit patient comfort and safety at end of life.
- Comfort Supplies**
To assist applicants with the purchase of medical supplies that would be considered beneficial to the comfort of patients at end of life. This is not meant to address individual patient needs.
- Education**
To assist applicants with furthering education on comfort and care related issues at end of life facing health care. These grants will not be issued to individuals, but will be used to provide a guest speaker and associated costs with holding a seminar or conference in St. John's to benefit many staff. The applicant must have an education session developed or a person of interest identified.

OPTIONAL: If you wish to also have your unit/area considered for Versacare Bed with air mattress please fill out this section:

- Please consider my unit/area to be considered for the Versacare Bed with air mattress. This would benefit patient care on my unit by: _____

GRANT REQUEST INFORMATION SECTION - CONTINUED

Description of item/need for which funds are requested (*attach supporting documentation if applicable*):

Please explain how this request would enhance the comfort, safety and/or palliative needs of patients in your unit or area.

Is this request for the replacement of an existing item? Yes No

What is the dollar amount requested (tax not included): \$_____

Have you obtained a price quote from a supplier? Yes* No

*If yes, please attach a copy of the price quote(s) and any supporting documentation

NOTES:

i) Should your application be approved through the *Comfort in Care Grants Program*, the item(s) you have requested will be acquired through the Purchasing Department of Eastern Health in accordance with the Public Tendering Act. As a result, the item(s) purchased may not be the exact item(s) you have requested.

ii) Your unit will have one year from the date the grant is awarded to complete any additional fundraising to purchase item(s) over the \$2,500 grant amount and submit purchasing documentation to the Health Care Foundation.

I certify that the information contained in this application is correct and that I have included any necessary supplementary documentation required for my request to be considered by the Selection Committee. Also, I give my consent to participate in activities surrounding the promotion of *Comfort in Care* should my unit be awarded a grant in this round of funding.

Applicant Signature

Date

PROGRAM APPROVAL SECTION

(Please have the Manager of your unit or area complete the following section and then forward to the Program Director for signature as indicated below)

MANAGER APPROVAL

By signing this form, I acknowledge that:

- the application does meet the eligibility requirements as stipulated in the *Comfort in Care* application guidelines;
- my unit has not received a *Comfort in Care* grant in the last twelve months

Manager's Name (please print): _____

Manager's Signature: _____

Manager's Phone/Pager Number: _____ E-mail: _____

Site and Office Number: _____

Comments:

PROGRAM DIRECTOR APPROVAL

By signing this form, I acknowledge that:

- I support the above request and agree that it would benefit the comfort and/or safety of patients in my Program as outlined;
- The request would not be otherwise available through the capital or operating budgets for my Program;
- I am not aware of any reason why the request should not be granted;
- The Program will assume any costs to be incurred above the grant amount;
- My Program will adhere to hospital policy pertaining to infection control, safety, ergonomics, etc., surrounding the purchase of any item(s)

Director's Name (please print): _____

Site and Office Number: _____

Signature: _____

Date: _____

Please return this completed application form and supporting documentation by **March 4, 2011** to:

Comfort in Care Program
Health Care Foundation
71 Goldstone Street, Suite 103
St. John's, NL A1B 5C3
Fax: (709) 777-5903

For additional information please contact the Health Care Foundation office at (709) 777-5901.