



**HEALTH CARE**  
FOUNDATION  
for hospitals & health centres here at home

## **Comfort in Care™ Grant Application Form 2019**

The Health Care Foundation's *Comfort in Care™* program generates funding for items that enhances the comfort and well-being of patients, residents and families.

We are pleased to offer a total of **\$60,000** in *Comfort in Care™* grants for 2019.

The Health Care Foundation, thanks to the generosity of MedicalMart, will also award four Breezy Ultra 4 portable wheelchairs valued at \$500.00 each. Please indicate on page 3 of the application form if you wish to be eligible for either of these items, and if so, how it would benefit your unit.

Thanks to our corporate sponsor, **Johnson Insurance**, the Gary Rowe Comfort in Care fund and all of our other donors who support the *Comfort In Care™* program.

To be eligible for the 15th round of *Comfort in Care™* grants, the following criteria must be met:

- The applicant must work within the facilities we support, including:
  - Health Sciences Centre
  - Nuclear and Molecular Medicine Facility
  - Waterford Hospital
  - Dr. L. A. Miller Centre
  - St. Clare's Mercy Hospital
  - Dr. Walter Templeton Health Care Centre
  - Pleasant View Towers
  - Caribou Memorial Veterans Pavilion; and
  - Le Marchant House
  
- 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.

**Please indicate the hospital or health centre facility:**

\_\_\_\_\_

### **STAFF INFORMATION SECTION**

**Name:** \_\_\_\_\_

**Position/Title:** \_\_\_\_\_

**Hospital Unit / Work Area:** \_\_\_\_\_

**Work Telephone:** \_\_\_\_\_ **Work E-mail:** \_\_\_\_\_



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## GRANT REQUEST INFORMATION SECTION

Please check the applicable category you are requesting funding for in your unit/area:

**Equipment**

*To assist applicants with the purchase of medical equipment and/or technology that will be beneficial to patient/resident comfort and safety that is not considered a capital equipment purchase.*

**Special Projects**

*To assist applicants 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/residents. This is not meant to address individual patient/resident 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 support 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.*

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:



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

What is the dollar amount requested (mandatory) \$ \_\_\_\_\_  
(this amount **must** include taxes, freight/delivery and any extra expense due to installation)

Have you obtained a price quote from a supplier?  Yes\*  No  
*\*at least one price quote is **mandatory** and must be attached to your application form.*

Have you obtained approval from Infrastructure and Facilities Management (if applicable)?  
 Yes\*  No  
*\*if yes, please obtain signature from Facilities*

**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) Should your application be approved through the *Comfort in Care™* grants program, the completed purchase requisition form must be submitted to Eastern Health purchasing by June 30, 2019.
- iii) 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.
- iv) Any requests for equipment which require installation, such as televisions and/or television mounts, must be first approved and signed off by Infrastructure and Facilities management. Any extra costs incurred for installation must be included in the dollar amount requested.

**OPTIONAL:**

**Breezy Ultra 4 Portable Wheelchair**

If you wish to have your unit/area considered for a portable wheelchair, please fill out this section:

- This would benefit patient care on my unit by:



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## 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.

Manager's Name *(please print)*: \_\_\_\_\_

Manager's Signature: \_\_\_\_\_

Manager's Phone/Pager Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Site: \_\_\_\_\_

### 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 Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**INFRASTRUCTURE AND FACILITIES MANAGEMENT APPROVAL (IF APPLICABLE)**

By signing this form, I acknowledge that:

- The requested item(s) will have additional cost for installation  
 Yes\*  No

*\*if yes, how much:* \_\_\_\_\_

Director's Name (*please print*): \_\_\_\_\_

Site and Office Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**APPLICANT APPROVAL**

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**

Please return this completed application form and supporting documentation by **March 4, 2019** 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.