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:** ______________________________

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: ______________________________

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.