**ONE-TIME PATIENT SERVICES FUNDING REQUEST FORM**

***One-Time Funding* Applications are accepted until April 30th**

**Instructions:**

1. Carefully read the criteria below to ensure that your project is eligible for funding. If you are unsure, please contact Tina Cooper, Executive Director, at extension 76585 or e-mail tcooper@hhsc.ca.
2. Complete this application ensuring that every question is answered. Incomplete applications will be returned.

Ensure that all attachments and written quotes are included and these are vetted by Hamilton Health Sciences Purchasing and/or the appropriate program depending on the nature of the product (i.e. Health & Safety, Biomed, Infection Control) to ensure that requests meet hospital standards and that quotes reflect best pricing. **Quotes *must* be valid through July 15, 2022.**

1. Sign and date the application form and also have the application signed by your department’s **Director or Vice President**. This indicates that Hamilton Health Sciences approves the Volunteer Association funding this request.
2. Keep a copy of the application for your files. If successful, you will be required to attach a .pdf of the quotes(s) through the electronic requisition to purchase (eRTP) process.
3. Send completed application and supporting documents to the attention of: Sandra Starr, Board Coordinator, Volunteer Association, Administration Office, 688 Concession Street. Electronic versions are encouraged. [starrs@hhsc.ca](mailto:starrs@hhsc.ca). **Please do not scan this cover page.**
4. Completed applications for funding that meet the criteria will be reviewed by the HHSVA Board of Directors at its May Board meeting. Following the funding decision by the Board, you will be notified in early June regarding the decision.

**Criteria for Funding:**

Through the patient services funding program, the Volunteer Association provides funding that enhances the **comfort and care** of patients within Hamilton Health Sciences. **One-time** funding requests are intended for items anticipated for long-term use such as blanket warmers, sleeper cots, wheelchairs, walkers and roho cushions.

**Ongoing** funding requests are annual requests for items or patient programs anticipated to be required year after year. For example, supplies for therapeutic recreation activities, etc. The application deadline for Ongoing funding requests is February 28th and requires an alternate application form.

It is not the role of this program to provide funding for:

• surgical/diagnostic/medical equipment or supplies • standard building maintenance

• staff furniture, appliances or equipment • publications or printed material

One-time Patient Services Funding requests are available for qualifying items up to $15,000 and there is a maximum three requests per department.

**PATIENT SERVICES**

**ONE-TIME FUNDING REQUEST FORM**

**Contact Information** (please provide all requested information)

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| --- | --- | --- | --- |
| Department: |  | Site: |  |

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| --- | --- |
| Contact Person: |  |

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| --- | --- |
| Position/Title: |  |

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| --- | --- | --- | --- | --- |
| Extension: |  | Email: |  | @hhsc.ca |

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| Meeting location for site visit to view donated equipment: |  | Level/Floor/  Wing/Colour: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Program Manager Contact Name: |  | Email: |  | @hhsc.ca |

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| Alternate Contact for future on-site follow up visit: |  |

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**One-Time Funding Request:**

**Last day applications will be received is April 30th**

Total Funds Requested: **(include shipping & installation, but do NOT include taxes)**

$

Please be specific

Equipment Requested

* If submitting additional request(s), please indicate the priority of this request in relation to other request(s)

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| --- |
| 1. Describe the desired equipment (or project) in detail. |
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| 2a. Describe the benefits to patients.    2b. Has this project been proven to provide benefit to patients? What evidence/experience do you have to support your claim? |
| 3. How many patients will this benefit per year? |
| 4. How will staff benefit? |
| 1. Who will take responsibility for maintenance? |
| 1. Completely and fully identify all the costs of this project. This application must include current written quotes vetted by Hamilton Health Sciences Purchasing or Capital Planning. Please **include installation and/or delivery fees**, but do not include taxes.   If funding for furniture is being requested, you must contact a HHS Capital Planner to ensure that the furniture meets hospital standards and to obtain a written quote. Quotes not through an HHS Capital Planner cannot be considered.  **Please** **Note:** Funding will be approved only for the amount requested. Additional costs will be borne by the department making the request. |
| 1. Have you sought funding from Hamilton Health Sciences or other sources? Which sources?   What was the outcome? Please specify and provide details. |

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| 8. Documentation Checklist  I have attached a recent written quote vetted by:  Hamilton Health Sciences Purchasing  Hamilton Health Sciences Capital Planning |

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| --- | --- | --- | --- |
| **Signature of Applicant** |  | ***Date*** |  |

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| --- | --- | --- | --- |
| **Signature of Director or Vice President** |  | ***Date*** |  |

***Please delete extra lines from this fillable form to reduce the number of pages in the document (do not scan cover sheet) and email to*** [***starrs@hhsc.ca***](mailto:starrs@hhsc.ca) ***(after signatures). Much appreciated!***