Grant Advisory Panel

Funding Application Form



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|  | | |
| **Tick the appropriate pillar** | | |
| **New & Emerging Services** | **Medical Equipment & Services** | **Impact Initiatives for Patients, Parents & Staff** |
| ☐ | ☐ | ☐ |

|  |  |
| --- | --- |
| Prepared By: |  |
| Email Address: |  |
| Phone Number: |  |
| Department/Ward/Office: |  |
| CHI Site: |  |
| Date Submitted: |  |
| Amount Requested:  VAT Amount:  Total: | €  € All applications **must** include VAT  € |
| GAP REF: (issued by CHF) |  |

**GRANTS ADVISORY PANEL – SUBMISSION GUIDELINES**

The Grants Advisory Panel (GAP) will consider initiatives with a value up to **€500,000** that meet one of the core pillars of funding:

1. New and Emerging Services/Development Initiatives
2. Advancing Medical Equipment and Systems
3. Patient, Family & Staff Impact Initiatives

**Please note that applications for Research and Innovation will be subject to a different process**

**Essential Requirements**

All applications over €25,000 are required to provide three quotes, where relevant and must be submitted with the application.

All requests will be assessed and scored against a set list of key criteria. These criteria will take into consideration donor and CHI priorities for funding and previously funded applications.

All sections of this application form must be completed and signed with all supporting documentation attached to clearly articulate the identified need and how this project sets out to address that need.

**As part of the application process, it is essential that applicants consult with their Head of Department and other relevant stakeholders whose areas may be impacted by the proposal, such as ICT, HR, and Finance. This ensures that all relevant costs are identified and included in the application. Where such costs (e.g., service, maintenance, etc.) are not covered by the Foundation, confirmation must be obtained from the CHI Finance team that these costs will be covered internally. In addition, formal sign-off from the relevant Clinical Lead is required.**

Applications will only be accepted as a **single PDF document**. Applications submitted in any other form, incomplete or multiple documents will be automatically excluded from the process.

On completion, the application form and it’s supporting documentation should be submitted as a single PDF document on the Children’s Health Foundation website \*\*this will be updated when we are ready to go live, and the link will be shared\*\*

**Funding Criteria:**

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| --- | --- | --- | --- |
|  | **Initiatives NOT considered appropriate for donor funding** | **Initiatives considered appropriate for CHF funding** | **Initiatives considered as key investment areas for CHF, due to their ability to deliver long term impact for children** |
|  | Maintenance Costs | Patient Experience and Engagement Programmes | New & Emerging Medical Technologies |
|  | Warranty Costs | Patient & Family Supports | Innovations In Health |
|  | Repair Costs | Patient Care & Assistance | Capital Development |
|  | Operational ICT | Equipment |  |
|  | Subscriptions Costs | Clinical Technology |  |
|  | Annual costs |  |  |
|  | On-going Salary Costs |  |  |

***Please Note:*** *By submitting this proposal, you confirm that all information included in this application is correct and can be used by the Foundation for information purposes. Awarded funding must be utilized within 6 months.*

**GRANTS ADVISORY PANEL – GRANT APPLICATION**

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| --- |
| **Request Title** |
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| --- | --- | --- | --- |
| **Project Timeline Summary** | | | |
| Start Date |  | End Date |  |

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| --- |
| **Background and Context: What is the project?**  *Please provide a summary for this project. Max 300 words* |
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| **The Problem: Please tell us why this project is needed. Please describe who this project is targeted toward and how they will benefit from this project?**  *What is the issue or need that this project aims to address for sick children in Ireland?* |
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| **Please describe what is currently in place and how this new project will improve the current situation.** |
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| **Evidence: What is the evidence base for this project?**  *Please include any reference to external sources* |
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| **Impact and Outcomes: Please describe how you monitor impact on an on-going basis? Please tell us what outcomes you are aiming to achieve with this project?**  *Please indicate the key qualitative and quantitative outcomes for this project and ensure that all proposed outcomes are clear and measurable. Any information included will be used by the Foundation to monitor the impact of grant funds* |
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| P**lease detail how many beneficiaries this project will impact on an annual basis?**  *Please include details if this project will have an influence / impact beyond the direct beneficiaries? Please include patient numbers/statistics where relevant.* |
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| **What, if anything, makes your project unique / innovative that could influence practice?** |
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| **Why would a donor want to support this, what is compelling about this project?**  *This question is mandatory to provide key information to donors on our goals and impact.* |
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| **Impact on Hospital Departments – Must be Completed** |

**As part of the application process, this section must be completed for your application to be considered.**

\*CHF do NOT fund the costs of software and maintenance on an on-going basis. Therefore, it is strongly recommended that you consult the **relevant** Department Head.

*Please confirm that you have consulted with the relevant Department Head and fill in the appropriate box below if your project will have an impact on resources for any CHI department e.g. Staffing/man hours, machine hours, extra costs or items such as service/maintenance contracts etc. This must be signed by the relevant Department Head e.g. ICT, HR, Clinical Engineering, Projects Office.*

|  |  |  |
| --- | --- | --- |
| **Department** | **Provide details & likely associated costs.** | **Department Head Signature** |
| Finance |  |  |
| ICT |  |  |
| Human Resources |  |  |
| Project Office |  |  |
| Clinical Engineering |  |  |
| Procurement |  |  |
| Laboratory |  |  |
| Pharmacy |  |  |
| Research & Innovation Office |  |  |

Equipment in excess of €25k will need to go through the CHI tendering process. Ensure you have consulted the Clinical Engineering Department in advance of submitting an application.

**Project Team**

*Please include contact details for the Key Contact overseeing the day-to-to day operations and information on all relevant persons in support roles: i.e. Finance, Communications etc.*

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| --- | --- | --- | --- |
| **Name** | **Position** | **Phone** | **Email** |
|  |  |  |  |
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**Project Budget**

Overall Summary budget (in Euro)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Budget Categories*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
| Staff Costs |  |  |  |  |
| Equipment Costs |  |  |  |  |
| Consumables / Materials |  |  |  |  |
| Other Costs |  |  |  |  |
| **Total** |  |  |  |  |

**Budget Categories Details / Workings**

**Staff/Costs (in Euro)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
| Salary \* |  |  |  |  |
| PAYE/PRSI  (11.15% Currently)† |  |  |  |  |
| Other |  |  |  |  |
| **Total per year** |  |  |  |  |

\* Please ensure you discuss with HR to determine all costs involved and detail accordingly.

† Current Employer PRSI costs total 11.05%

If it is proposed to employ more than 1 individual, please complete a separate box for each individual.

**Equipment costs (in Euro)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
| Equipment |  |  |  |  |
| Extras Required |  |  |  |  |
| Other costs: |  |  |  |  |
| **Total per year** |  |  |  |  |

**Consumables / Materials costs (in Euro)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total per year** |  |  |  |  |

**Other costs (in Euro) – must be appropriately described and justified**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Description*** | ***Year 1*** | ***Year 2*** | ***Year 3*** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total per year** |  |  |  |  |

**Have you previously been awarded GAP funding? If yes, please list previously approved GAP funding details**

|  |  |  |
| --- | --- | --- |
| **Approved GAP Projects**  ***Please include reference number, project title and any other information you deem relevant*** | | |
| **Reference** | **Description** | **Other Information** |
| GAPXX- |  |  |
| GAPXX- |  |  |
| GAPXX- |  |  |

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| **Application Checklist – Please confirm you have completed the following** | |
| Applicant Details - page 1 |  |
| Thoroughly Read Essential Requirements - page 2 |  |
| Grant Application Details - pages 3-6 |  |
| Impact on Hospital Departments – page 7 |  |
| Budget / Costs – page 8 - 9 |  |
| Included all required documents e.g Quotes etc. |  |
| Application is signed by all parties |  |

***CHI Authorization***

|  |  |
| --- | --- |
| **Proposer** | |
| Name |  |
| Signature |  |
| Date |  |
| **Department Head** | |
| Name |  |
| Signature |  |
| Date |  |

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| **CHI GAP Review Committee Sign Off** | |
| Name |  |
| Signature |  |
| Date |  |

Please list additional documentation in support of this application:

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| --- | --- | --- |
| **APPENDICES**  ***Please check you have included the essential documentation required in support of this application and all documents are merged as one pdf prior to submission*** | | |
| **Appendix** | **Document Type** | **Received by CHF** |
| Appendix 1 | E.g. Supplier Quotes |  |
| Appendix 2 | E.g. Supporting Project Proposal |  |
| Appendix 3 |  |  |

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| --- | --- |
| **CHF Use Only – Children’s Health Foundation** | |
| CHF Decision: |  |
| Conditions Applied: |  |
| Signature: |  |
| Date Approved: |  |