Families First Funding Call

Application Form 2025



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| **New & Emerging Services** | **Impact Initiatives for Patients, Parents & Staff**  |
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| Prepared By: |  |
| Email Address:  |  |
| Phone Number: |  |
| Department: |  |
| CHI Site:  |  |
| Date Submitted: |  |
| Amount Requested:VAT Amount:Total: | €€ All applications **must** include VAT€ |
| GAP REF: (issued by CHF) |  |

**Families First- GRANTS ADVISORY PANEL – SUBMISSION GUIDELINES**

**Given the upcoming transition to the new Children’s Hospital and the ongoing work from CHI’s procurement and support teams, we have decided to omit equipment from the call for 2025**. The focus will be on better outcomes for patients, their families and staff. We want to use the generous donations of our supporters to optimise the patient experience and ensure teams are empowered to support initiatives in relation to this. The Families First Grants Advisory Panel (GAP) will consider initiatives with a value up to **€500,000** that meet one of the priority core pillars of funding:

1. Patient, Family & Staff Impact Initiatives
2. New and Emerging Services/Development 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 including VAT, 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

[https://www.childrenshealth.ie/funding-applications/](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.childrenshealth.ie%2Ffunding-applications%2F&data=05%7C02%7Cnjauhari%40childrenshealth.ie%7Ca438a8c69b5a42a8548908dda2d3dbc1%7Ca69fca546fdf4cb29c07a4a1e93df918%7C0%7C0%7C638845753299798660%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=7KY5qa4p3%2BAJr6HQlAsakJsPIuGHlycyGPUMqNEwbGk%3D&reserved=0)

**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 that advance the patient and family experience |
|  | Repair Costs | Patient Care & Assistance |  |
|  | Operational ICT |  |  |
|  | Subscriptions Costs | Clinical Technology |  |
|  | Annual costs | Enhancing healthcare teams performance & experience |  |
|  | 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.*

**FAMILIES FIRST FUNDING CALL – 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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| **Will this project be transferable to the New Children’s Hospital?** *If yes, ensure to provide Authentication from CHI Commissioning Team* |
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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. You must get a signature of approval from the area you need support to deliver project otherwise your application will not be accepted. See below examples

***Please confirm that you have obtained approval from any relevant departments if your project will require their support.***

 *For example, if your project will need: Additional staffing, ICT setup, support, or testing, Equipment or procurement tenders, Additional costs such as service or maintenance contracts etc. then you must get approval and a signature from the appropriate department(s). This ensures they’re aware of and agree to support the delivery of your project if it is successful.*

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*Bottom of Form*

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| **Relevant Department**  | **Required Support & Estimated Costs** | **CHI Staff Approval Signature** |
| Medical Devices Committee | Please supply your letter of approval with application – without this your project will not be considered | Chair of MDC |
| Finance   |   | Fiona Brady |
| Commissioning |  | Julia Lewis |
| CHI Site Leads |  | Paul Harding / Tracey Wall / Turlough Bolger |
| CDON or Site DON |  | Grainne Bauer |
| HSCP |  | Vivienne Hand |
| Clinical Director |  | CD A B or C |
| ICT  |   | Neil O Hare |
| Human Resources   |   | David Mableson |
| Estates CHI Office  |   | Sean Browne |
| Clinical Engineering  |   | Philip Harnett |
| Procurement   |   | Robert Keogh |
| Laboratory   |   | Michael McDermott |
| Pharmacy  |  | Michael Fitzpatrick |
| Research & Innovation Office   |   | Paul McNally |
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**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 for your project: i.e. Finance, Nursing, HR, ICT, Communications etc.*

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

Overall Summary budget (in Euro)

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| ***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)**

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| --- | --- | --- | --- | --- |
| ***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) Ensure you have approval from the Medical Devices Committee before you submit your application**

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

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

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

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

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| --- | --- | --- | --- | --- |
| ***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**

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| **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 Review Panel Authorization***

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

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| **CHI Funding Call - 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 | E.g. Dates of Essential Committees |  |

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