Comfort in Care™
2025 Grant Application Form

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

Through the generosity of our donors and philanthropic community, we are pleased to offer **$100,000** in Comfort in Care™ grants for 2025. Special thanks to **belairdirect** for their ongoing support.

Additionally, thanks to a generous contribution from **MedSurg Solutions Inc.**, a **Pulse Oximeter – RAD5 (valued at $900)** will be awarded as a dedicated grant. If you would like to be considered, please indicate this in the application.

ELIGIBILITY

To qualify for a Comfort in Care™ grant:

✓ You must work at a facility supported by the Health Care Foundation, 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
- Le Marchant House
- Kidney Care Centre

✓ Each grant funds up to **$2,500** per item.

✓ Requests exceeding **$2,500** must include confirmation that additional funding will come from:

- Department budgets;
- Department-hosted **Healthy Leg Day** events; and/or—
- **Comfort in Care™ Fundraising Initiatives**.
  *(For details, contact **Gennette Martin** at (709) 777-5926.)*

APPLICANT INFORMATION

(Please print).

Name: _____

Position/Title: _____

Unit/Work Area: _____

Work Phone: _____ **Work E-mail**: _____

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PULSE OXIMETER GRANT

☐ I would like to be considered for the Pulse Oximeter Grant, as this device would benefit patients in my department or unit.

☐ Not applicable to my application.

FUNDING REQUEST

Describe the item or need for which funds are requested.
(Attach supporting documentation via the function below, if applicable).

Please describe how this request will enhance patient comfort, safety, or palliative support in your unit or area.

Replacement Request: Is this item replacing existing equipment?

☐ Yes ☐ No

Total Amount Requested: $_____ *(Include taxes, freight, delivery, and installation costs).*

Have you obtained a price quote from a supplier? ☐ Yes* ☐ No
**A minimum of one price quote is mandatory and must be attached to your application form.*

MANAGEMENT APPROVAL SECTION

(Please have the manager of your unit or area complete the following section, 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: _____

Does your application require you to receive approval from Infrastructure and Facilities Management?

☐ Yes ☐ No

Infrastructure and Facilities Management Approval
(If applicable.)

By signing this form, I acknowledge that the requested item(s) will have an additional cost for installation.
☐ Yes* ☐ No

***If yes, how much**:* _____

Director's Name *(please print)*: _____

Site and Office Phone Number: _____

Signature: _____

Date: _____

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IMPORTANT NOTES

- Approved items will be procured through **NL Health Services** in accordance with the **Public Tendering Act** and may differ from the exact item requested.
- Grant recipients must submit the completed purchase requisition form to NL Health Services Purchasing by **June 30**, **2025**.
- Departments will have **one year** to secure any additional funding needed beyond the grant amount.
- Equipment requiring installation (e.g. televisions, mounts) must receive prior approval from **Infrastructure and Facilities Management**, with installation costs included in the request.

APPLICANT CERTIFICATION

By submitting this application, I certify that:

- All information provided is accurate, and supporting documents are attached.
- If awarded, I consent to participate in promotional activities for Comfort in Care™.
- I will provide an impact statement and a photo to the Health Care Foundation in a timely manner upon receiving the grant.

Applicant Signature _____ **Date** _____

SUBMISSION DETAILS

- Completed applications and supporting documents must be submitted by **Friday, March 7, 2025** to **Gennette Martin –** hcf@healthcarefoundation.ca.
- For inquiries, contact the Health Care Foundation office at **(709) 777-5901**.
- **Incomplete applications** (missing dollar amounts, quotes, or approvals) **will not be considered.**
- **Successful applicants** will be notified by **March 31**, **2025**, via email.