

IMPORTANT FUNDING ANNOUNCEMENT FOR THE GOOD SAMARITAN HOSPITAL FOUNDATION WISH PROGRAM

You are invited to submit funding proposals to the Good Samaritan Hospital Foundation’s Women Investing in Samaritan Health (WISH) program.

- GSH Foundation WISH Giving Circle. Open to departments and medical staff of Good Samaritan Regional Medical Center. Programs/projects must be designed to enhance health/health care of women and children. Proposals are due October 1, 2010. Award notification in March 2011.
 - WISH grants: \$5,000; one year
 - WISH large grants special projects: \$25,000 over two years

WOMENS GIVING CIRCLE -- FUNDING GUIDELINES

- Funding will be given to programs and projects that address the health care needs of women and children (boys and girls) under age 18.
- Requests pertaining to both physical and mental health will be considered.
- Funding requests should be **initiated by hospital-based staff or physicians**; special consideration will be given to **budgeted requests, collaborations among hospital departments.**
- GSHF’s WISH fund will support both program and capital needs.
- Special consideration will be given to requests that incorporate evidence-based information and/or specific outcome measurements.

APPLICATION

1. Title of Program/Project (If capital request, specify equipment or items requested) _____
2. Principal Applicant: Name _____
 Title _____ Department _____
 Organization _____
 Address _____
 Phone _____ Fax _____
3. Total Amount Requested _____
4. **(For those requesting capital equipment):**
 Did you first submit your request to the hospital’s annual capital budget? _____
 Please state reason why the request was not funded in the capital budget:

EQUIPMENT REQUEST: COMPLETE THIS SECTION

Name:		Phone #: (we may need to contact you):
Facility Name: _____	Department Number: _____	NOTE: <i>Some purchases may not be capitalizable and must be charged through the requesting department's Operational Budget. Upon approval, you will be notified and asked for confirmation before being charged.</i>
Department Name:	In This Year's Budget: __Yes __No	
Equipment Needed:		Date Requested: Date Needed By:
Justification: <input type="checkbox"/> Safety <input type="checkbox"/> Regulatory compliance <input type="checkbox"/> Maintain Primary Svc. <input type="checkbox"/> Enhance Revenue <input type="checkbox"/> Reduce Costs <input type="checkbox"/> Customer Service <input type="checkbox"/> Aesthetics <input type="checkbox"/> Replacement (If replacement, what is it replacing: <input type="checkbox"/> PC/Win 3.1, <input type="checkbox"/> PC 486, <input type="checkbox"/> HP/II or <input type="checkbox"/> III <input type="checkbox"/> Other)		
IF THIS REQUEST IS FOR NEW EQUIPMENT/SOFTWARE , PLEASE ANSWER THE QUESTIONS BELOW:		
Describe the equipment's/software purpose and function. Be specific.		
How will the equipment/software benefit the hospital (clinically & financially)? Be specific.		
3. If the equipment/software is not purchased, what impact will there be to clinical services and/or revenue? Other options if request is not approved? Be specific.		
IF THIS REQUEST IS FOR REPLACEMENT EQUIPMENT , PLEASE ANSWER THE QUESTIONS BELOW:		
1. Describe how the equipment/software currently functions and how the equipment contributes to patient care and/or is of financial benefit to the hospital. Be specific.		
2. Describe the reasons why the replacement is required and provide any available supporting information. Be specific.		
3. If the equipment/software is not replaced, what impact will there be to clinical services and/or revenue? Other options if request is not approved? Be specific.		

PROGRAM REQUEST: COMPLETE THIS SECTION

- 6. Provide a concise summary of the program/project objectives and the need the program/project addresses.

- 7. Describe additional financial support (if any) for the project detailed in this application.

- 8. Describe plans for support of this project once the grant funds are spent.

- 9. Budget:

Awards are made for up to one year and can begin at any time during the year.
Budgets should be separated according to calendar year.

	Year 1	Year 2 (for larger grant programs)
Salaries/benefits		
Services/supplies		
Equipment		
Overhead (limited to 15% of total amount requested)		
Other (please specify)		

Please itemize and justify the requested budget below or on attached sheets:

Submitted By:

Principal Applicant

Date

Supervisor/Department Manager

Date

Signature of Hospital Collaboration:

Samaritan-affiliated co-applicant (if needed)

Date

Please submit completed application to:

Good Samaritan Hospital Foundation
3600 N.W. Samaritan Drive
Corvallis, OR 97330