

# Facility Improvements and Enhancements Application form

## Form Preview

### Applicant Details

\* indicates a required field

#### Eligibility Criteria

You must be a permanent GCHHS staff member to apply for funding. Temporary GCHHS staff members must be in their role of employment during the period in which the project is funded.

**As part of your acceptance of the generous gift from a valued Gold Coast Hospital Foundation Donor,** you will be required to complete an Acquittal form. This form will be sent to you once handover of the item is completed. The submission will include a short video on how this donation has helped your patient care.

#### Contact

**Name \***

First Name

Last Name

**GCHHS ID No. \***

**Position \***

**Facility \***

**Unit \***

**Department \***

**Delivery Instructions \***

i.e Loading Dock

**Unit Address for Improvements \***

Address

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Suburb State Postcode

  

Must be an Australian postcode.

**Phone \***

**Email \***

Must be an email address.

**Mobile Phone \***

## Project Details

\* indicates a required field

**Which departments will benefit from this improvement or enhancement? \***

List all that apply.

**Will this project improve: \***

- One facility only  
 Multiple health facilities

**Project Title**

**How many rooms will be enhanced by this project? \***

Must be a number.

**Description of the project and the health need/condition or illness it will address:**

Word count:

Must be no more than 100 words.

Provide a short description (100 words recommended) of your project - what are you out to do?

**How did you identify the need for this project? \***

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## Form Preview

Word count:  
Must be no more than 150 words.

**Describe a clinical scenario of how this project will improve patient outcome/s: \***

Word count:  
Must be no more than 150 words.  
Please give a patient example to explain the benefit where possible.

**Estimate the number of patients who will benefit from this project per year: \***

Must be a number.

**What is the most common age group of patients who will benefit from this program/equipment item? \***

- Infants
- Children
- Adolescents
- Young Adults
- Adults
- Elderly

If infant, children or adolescent then the application will be submitted to the GCHHS Women and Children Committee for assessing. Please do not select these if not relevant to predominantly relating to children.

**What is the anticipated lifespan of this project and any items purchased? \***

Items requested for project

| Item requested (make and model) | Quantity requested | New or replacement |
|---------------------------------|--------------------|--------------------|
|---------------------------------|--------------------|--------------------|

|                      |                      |                      |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | Must be a number.    | <input type="text"/> |

Facility Improvement

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## Form Preview

### Does the room/facility improvement relate to children? \*

- Child related
- Not child related

If infant, children or adolescent then the application will be submitted to the GCHHS Women and Children Committee for assessing. Please do not select these if not relevant to predominantly relating to children.

### Attach a completed and approved GCHHS Accommodation Change Request form \*

Attach a file:

The form is located on the GCHHS Intranet. The application cannot proceed without this signed authorisation.

### How will you promote/inform the public of GCHF's participation in the project? \*

Word count:

Must be no more than 150 words.

## Budget

\* indicates a required field

Funds requested

### Total amount requested \*

\$

Must be a dollar amount.

What is the total financial support you are requesting in this application?

### Is this equipment/project on the approved procurement list? \*

- Yes
- No

Attach at least two quotes for the items requested:

Please list in order of preference

### First quote \*

Attach a file:

### Second quote \*

Attach a file:

Explain if there is only one supplier available for these item/s

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### Updated quote

Attach a file:

### Updated price

Must be a dollar amount.

## Other Funding Sources

**Have you applied for or received other funding for this equipment/project? \***

- Yes  
 No

If yes, please specify

| Funding source       | Amount requested        |
|----------------------|-------------------------|
| <input type="text"/> | \$ <input type="text"/> |
| <input type="text"/> | \$ <input type="text"/> |
| <input type="text"/> | \$ <input type="text"/> |
| <input type="text"/> | <input type="text"/>    |

### Total requested from other sources

\$

This number/amount is calculated.

## Related recurrent or maintenance costs

| Cost                 | Amount                  |
|----------------------|-------------------------|
| <input type="text"/> | \$ <input type="text"/> |
| <input type="text"/> | \$ <input type="text"/> |
| <input type="text"/> | \$ <input type="text"/> |
| <input type="text"/> | <input type="text"/>    |

### Total recurrent/maintenance costs

\$

This number/amount is calculated.

**Will your Department/Unit support these costs? \***

- Yes  
 No

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### Certification

\* indicates a required field

#### Applicant declaration

- I have read and understood the terms and conditions for Equipment and Facilities Enhancement Grant and agree to abide by those terms and conditions.
- I certify that to the best of my knowledge the statements made within this application are true and correct.
- All associated parts with this project have agreed that this application accurately represents the project.
- All needed authorisations and consents have obtained (patient case study, photos, etc.)

**I have read and agree to the terms and conditions \***

yes

**Declarant Name \***

First Name

Last Name

**Date \***

#### Divisional General Manager

As the applicants Divisional General Manager, I confirm the proposed equipment/project will enhance the Unit and improve patient outcomes as outlined in this application. I therefore endorse this application.

I confirm the above applicant will provide a case study report to Gold Coast Hospital Foundation involving a local patient within 60 days of receiving the equipment/project.

**Name of Department Director \***

First Name

Last Name

[Click here](#) to print the Department Director approval form and upload your completed form below. Applications can not proceed without authorisation.

**Signed Department Director approval \***

Attach a file:

The application cannot proceed without authorisation.

[Click here](#) to view the Terms and Conditions

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**I have read and agree to the terms and conditions \***

yes

**Date \***