Southwest Florida Healthcare Coalition

Request for Funding

The mission of the Southwest Florida Healthcare Coalition is to support regional healthcare emergency preparedness, response, and recovery capabilities through collaboration, training, and planning.

REQUEST FOR FUNDING PROPOSAL		
APPLICANT INFORMATION		
Project or Purchase Title:		
Project Type: ☐ **Training/Education** ☐ **Supplies/Equipment** ☐ **Exercise or Other (Please describe):**		
Date:	**Amount Requested:**	
Organization Name:		
Current address:		
City:	**State:**	**ZIP Code:**
Agency Type: For Profit ☐ Non-Profit ☐ Government ☐ Other:		
CONTACT PERSON INFORMATION		
Name:		
Address:		
City:	State:	ZIP Code:
Phone:	Email:	
Title:		
SHIPPING INFORMATION		
Recipient Name:		
Company Name:		
Address:		
City:		
State:		Zip Code:
WHAT GAP YOU ARE FILLING		
Plan and conduct coordinated exercises with health care coalition members and other response organizations.		
☐ Educate and train on identified preparedness and response gaps.		
☐ Identify and coordinate resource needs during an emergency.		
☐ Train and exercise to promote responder's' safety and health.		
☐ Assess regional health care resources.		
☐ Distribute resources required to protect the health care workforce.		
PROJECT PHASE		
Is this a new project?		
☐ Yes ☐ No		
Does this sustain an existing capability?		
☐ Yes ☐ No		
Does this project build/enhance a capability?		
☐ Yes ☐ No		
Will items be used for daily use?		
☐ Yes ☐ No ☐ N/A		
Can this project be completed by 06/30/24?		
☐ Yes ☐ No		
If this project is not funded in the current cycle, would you like it to be considered in future cycles?		
☐ Yes ☐ No		

PROJECT DESCRIPTION (*Refer to Information packet for list of gaps*)

IMPACT (*Please give additional details below*) ☐ **Statewide** ☐ **Regionwide** ☐ **Countywide** ☐ **Municipality** ☐ **Multi-Agency** ☐ **Single Agency**

Please describe how this project contributes to the coalition mission and helps fulfill one or more of the prioritized gaps. See instruction page 2 for gaps.

If you are requesting items, please describe where they will be stored and plans for any training and maintenance that may be required.

Health Planning Council of Southwest Florida, Inc. Purchase Authorization

Requestor Name:_____ **Date of Event (if applicable)**: _____

Date Requested: _____

All information must be complete, or the request will not be processed. Include ALL services for which funding is being requested. Payments will be made directly to the vendor unless a reimbursement has been pre-authorized. If the vendor is new, the vendor will be required to complete a W-9. All boxes should be completed before request is placed.

TO BE FILLED OUT BY PARTICIPANT		
ITEM	**VENDOR**	**$ AMOUNT**

Select One

☐ **We have attached bids (at least 3, can be internet quotes or prices) and chose a source based on:**

_____

_____

☐ **The product or services is unique and only available from a single source. We have determined the cost reasonable and commensurate with the value received. (Please explain)**

_____

_____

Signature:_____ **Date:**_____