



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 ☐ 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 (If applicable)

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, train and conduct coordinated exercises for members and other related organization on identified preparedness and response gaps.

☐ Assess and coordinate distribution and sharing of regional healthcare preparedness and response resources.

☐ Assess and address gaps in preparedness for specific populations such as children, pregnant women, seniors, individuals with access and functional needs, including people with disabilities, and others with unique needs.

☐ Identify and work to fill gaps related to health care worker and responder safety and resilience.

☐ Promote the value of health care and medical readiness particularly among clinicians and community leaders.

PROJECT PHASE

Is this a new project?

☐ Yes ☐ No

Dose this sustain an existing capability?

☐ Yes ☐ No

Dose 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 06/30/27?

☐ 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

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.

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 Requested: _____ Date of Event (if applicable): _____

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 that the cost is reasonable and commensurate with the value received. (Please explain)

Signature: _____ Date: _____