**Covenant Cares Funding Request**

If you have questions about completing this form, please contact:

Brittani Kite: (806) 725 – 0527 brittani.kite@covhs.org

E-mail, Interoffice or Fax Completed Form to Covenant Health Foundation:

* Fax: (806) 723 – 6256
* 3615 19th Street, Lubbock, TX 79410 at KECC
* Covenant Health Foundation Mailbox #368

Covenant Cares Mission Statement and Funding Process:

**The Mission of Covenant Cares is “to inspire giving to go above and beyond our promise through innovative and impactful ideas in need of support to delight our community of caregivers.”**

The Covenant Cares Funding Board will determine if this funding request falls in line with the mission and you will be notified following the quarterly funding board meeting. This application allows you the opportunity to share the vision of this funding request with the Board so be sure to include why these funds are needed and how they will help enhance patient or caregiver experience.

The Funding Board meets quarterly to review funding request. You will be notified the time and date of the meeting and should be available to answer questions during that time, should the need arise.

1. **Information**
	1. What are you requesting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Total Cost of request?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. Date of Application:
	4. Department Responsible:
	5. What need will it fulfill? (Please keep it brief as you can provide more detail below on Section #2).
	6. Where Equipment will Reside (Please include department and address for delivery):

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **APPLICATION CONTACTS** | **Name** | **Position** | **Phone** | **Email** |
| **Primary** |       |       |       |       |
| **Other** |       |       |       |       |
| **Other** |       |       |       |       |

1. Primary Objectives (Focus on how this funding opportunity can provide opportunities to live out our promise of “Know Me, Care for Me, Ease my Way” for caregivers or patients):
	1.
	2.
	3.
2. **Please attached as much supporting documentation as you need to make your case for funding. Testimonials and letters of support are encouraged.**
3. **Total Amount Needed for Project: $**

Details of Project:

* 1. Price Quote will hold for       days (Quotes must be able to hold for at least 60 days or long enough to make it through the funding decision process, which is a max of 90 days) **\*Please attached vendor price quotes, photos, specs, warranties, etc.** If approved, applicant or manager will be asked to fill out additional information about the product/services.
1. What is or will be the frequency of use for this piece of equipment? (Please provide documentation)
2. Who will directly benefit from this?

By signing this form, APPLICANT agrees to assist the Covenant Cares Funding Board with the fund request process. Assistance includes: gathering information, providing feedback on the validity of information in the proposal, follow up reports and providing documentation of expenditures and outcomes.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name:

Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name:

Vice President Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:

\*must obtain VP’s signature for your application to be reviewed.

Funding Letter Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Funding Completion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

End of Project Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Posted to Spreadsheet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes:

**For Covenant Foundation Use Only:**  Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved: \_\_\_\_\_\_\_\_\_\_ Amount Approved: \_\_\_\_\_\_\_\_\_\_ Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_