Request for Funds from Shattuck Partners, Inc.

Before Applying for Funds:

1. Identify an activity, program, or other offering that will improve the quality of life of your patients.
2. Discuss your ideas and plans with your manager.
3. Review available hospital budgets for funds that might be used for this need. **Only needs which cannot be met by available hospital resources will be considered. Please consult with LSH Administration/Fiscal Services prior to applying.**
4. If you are requesting a renewal of funding, you must reapply using this form unless alternate plans have been made.

To APPLY: Please fill out this form in its entirety, make a photocopy for your files, and drop the original into the Shattuck Partners mailbox (LSH Mail Room). Please contact us anytime with questions at 617.971.3931 or emondon@shattuckpartners.org.

To RE-APPLY: Reapplications must submit this form, providing updated information where necessary along with updated signatures. You may attach a copy of your original application, indicating "see attached" where information remains the same.

At a minimum, applications are reviewed twice per year, once in February (deadline February 1st) and once in September (deadline September 1st). Applications are reviewed at other times as board business permits. Please feel free to contact us any time with ideas and questions about any potential funding requests. Early applications are strongly encouraged. The decision to fund is at the sole discretion of the Shattuck Partners Board of Directors and is based upon a number of factors including availability of funds.

Basic Information

Today's Date __________________ Your Name: ________________________ Position: __________________________

Unit/Department: ____ Phone: _______________________________

Amount of money requested (please complete worksheet on reverse): ____

Timeline of activity (one-time, recurrent or ongoing; length of activity; anticipated start date):_____________________

____

Description of Intended Purchases/Expenses

What will be done or offered?

____

____

____

Briefly, what and how much will be purchased to carry this out? (Itemize supplies, etc. on reverse)

____

____

How will this program be managed, and by whom?

____

____

Please attach a separate document (maximum of one page) describing:

- The anticipated benefits to patients, both short- and long-term
- The profile of the patients who would benefit from this purchase/expense. For example, please indicate the approximate number of patients who will be impacted by this and other information describing the patients including unit/department, typical length of stay, typical treatment protocols and comorbidities, etc.

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Budget Categories	Description	Expenses
Additional Personnel:	___________________________________	__________________________
Equipment:	___________________________________	__________________________
Supplies:	___________________________________	__________________________
Construction:	___________________________________	__________________________
Training:	___________________________________	__________________________
Travel:	___________________________________	__________________________
Other 1:	___________________________________	__________________________
Other 2:	___________________________________	__________________________
Total:		$ _________________________

Additional Notes:____

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Statement of Intent

If funding for my request is granted by Shattuck Partners, Inc.:
I agree that the above-described project/activity/initiative and its administration will abide by all regulations, policies, and procedures of the Lemuel Shattuck Hospital and of Shattuck Partners, Inc.
I agree, before any expenses are incurred, to review all anticipated expenses with Shattuck Partners, Inc. and when applicable to provide to Shattuck Partners, Inc. all written quotes showing vendor documented rates for all anticipated expenses. I also agree to provide original receipts for all actual expenses to Shattuck Partners within the timeframe required by Shattuck Partners. I agree to provide periodic documentation and reporting as required by Shattuck Partners. I understand that only those funds for which original receipts are provided up to the approved funding amount and within the confines of the project/activity/initiative will be reimbursed and that any funds advanced to me but not spent on approved items (or not supported with original receipts) must be refunded to Shattuck Partners within one week of the end of the calendar quarter during which funding was received.

Signature of Applicant: ____ Date: ____________________

Supervisory Approvals

I agree that the above-described project/activity/initiative is a feasible and allowable one for this staff to manage within the confines of her/his immediate job, and that we have explored other hospital resources before submitting this request for funding.

Signature of Supervisor: ____ Date: ___________________

Signature of Senior Manager (if different): ____ Date: ___________________

Shattuck Partners, Inc., an independent 501(c)(3) nonprofit organization, strives to improve the quality of life of patients at the Lemuel Shattuck Hospital by funding programming and supplemental support services.
www.shattuckpartners.org

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