

# PCHF FY24 Annual Grants Application Form

## Form Preview

### Overview

\* indicates a required field

#### Our Purpose

Perth Children's Hospital Foundation Ltd. (PCHF) is the official and largest funder of the Perth Children's Hospital and the wider Child and Adolescent Health Service after government. Our purpose is to fuel the fight on the frontline to help children get well and stay well.

#### Primary Focus

The primary focus of the Foundation is to promote the control and/or prevention of disease in children. The Foundation's fundraising efforts complements, rather than substitutes, the funding provided to the hospital and broader health service by Government. The Foundation funds:

- Ground-breaking research
- The most advanced equipment and technology
- The expertise of highly trained clinicians from Australia and around the world
- Innovative education and training programs
- Positive patient experiences

#### PCHF Grant Application Guidelines

Before applying for a PCHF grant, applicants should familiarise themselves with the [PCHF Grant Application Guidelines](#), [PCHF Grant Application Process](#), and eligibility criteria available on our [website](#).

For any queries regarding the PCHF Grant Application Guidelines, Process, eligibility or filling out this application form, please contact us on (08) 6456 5550 during business hours or email [grants@pchf.org.au](mailto:grants@pchf.org.au).

**Please confirm that you have read the PCHF Grant Application Guidelines. \***

☐ Yes, I have read the guidelines.

#### Perth Children's Hospital Foundation Objectives

Projects that aim to transform the future of child health, address critical areas of unmet need and promote the control or prevention of disease in children are encouraged to apply. Whilst it is expected that some projects funded by the Foundation will relate to the treatment or care of children suffering injury, or the improvement in the general health and well-being of children and adolescents throughout Western Australia, these will be in the minority.

**Please indicate which objective(s) your project will set out to accomplish. \***

- ☐ Provide school children with information and education on the health promotion and the prevention or control of disease in children.
- ☐ Provide information on the prevention or the control of disease in children to health care professionals, children suffering with a disease and the families, carers of children suffering with a disease and the general public.

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- ☐ Promote and assist organisations and facilities which care for, treat and rehabilitate children suffering with a disease.
- ☐ Provide relief and assistance to children suffering from a disease, including the provision of relief and assistance to their families and carers.
- ☐ Promote, fund and assist organisations and individuals to undertake research or study aimed at detecting, diagnosing, preventing, treating or controlling diseases in children and, where practical to do so, to elevate and disseminate such study or research.
- ☐ Promote community awareness of and community participation in issues and activities relating to the prevention or control of disease in children.
- ☐ Please tick this box if your project relates to paediatric health conditions, injuries, or health burden but not diseases, as well as the above objective that most closely relates to your project.

Please tick all that apply.

## Eligibility Criteria

Please answer each of the below questions to assess your eligibility for funding. Please note, "core business" relates to equipment procurement, projects, and clinical positions that are essential to day-to-day operations and are core to the delivery of paediatric health services throughout Western Australia and/or are seen by PCHF to be the responsibility of the government to fund. Please find the [PCHF Grant Application Guidelines here](#) for further information. If you are uncertain if your project meets PCHF's eligibility criteria, please email [grants@pchf.org.au](mailto:grants@pchf.org.au) for advice and the PCHF Grants Team will respond as soon as possible.

### 1. Has the project received all relevant CAHS approvals prior to submission? \*

- ☐ Yes ☐ No

E.g. Finance, Medical Technology and Management Unit/Product Evaluation Standardisation Committee etc.

### 2. Is the project/program being led by someone other than a PCH or CAHS employee? \*

- ☐ Yes ☐ No

### 3. Will the project or program be delivered outside PCH or CAHS-approved sites? \*

- ☐ Yes ☐ No

### 4. Is the request for funds to replace, repair, or upgrade core equipment? \*

- ☐ Yes ☐ No

### 5. Is the project or program considered core to the day-to-day operations of the PCH or CAHS? \*

- ☐ Yes ☐ No

### 6. Does the application fund core clinical positions? \*

- ☐ Yes ☐ No

### 7. Does the project or program fund personal academic studies? \*

- ☐ Yes ☐ No

### 8. Has this project been funded by CAHS or the government previously? \*

- ☐ Yes ☐ No

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**If you have not yet obtained all relevant CAHS approvals, which approvals are still outstanding and when do you expect to receive those?**

**If yes, please explain what was funded previously and why CAHS or the government is not able to fund this project. We strongly recommend contacting us to discuss this point, prior to continuing your application.**

Projects which have selected Yes to any items from 2 to 7 above are not eligible for funding from PCHF.

Please review the [PCHF Grant Application Guidelines](#), [PCHF Grant Application Process](#), and eligibility criteria available on our [website](#).

You are welcome to contact the PCHF Grants team at [grants@pCHF.org.au](mailto:grants@pCHF.org.au) or 6456 5550 to further discuss your project's eligibility for PCHF funding if required.

## PCHF Application Process

- 1.Applications will be processed by the Foundation in line with the Grant Application Process detailed in the [PCHF Grant Application Process](#) document.
- 2.You will be notified of the outcome of your application by the PCHF Grants Team following the Grant Sub-Committee meeting at which your application was considered. For all grants requesting funding over \$20,000, full board approval is required. You will be notified if your application is progressing for full board approval, and again if it is successful after full board review.
- 3.If your application is successful, please be aware that your project will not be able to commence until a matching donor has been secured by PCHF. You will be notified when a donor has been identified and therefore when your project can commence. In some circumstances this can take several months, so please consider this when seeking funding for time sensitive projects. In the event your project requires commencement by a specific date, the Foundation strongly advises to discuss your project with a member of the Foundation's grants team prior to submission via [grants@pCHF.org.au](mailto:grants@pCHF.org.au).
- 4.Perth Children's Hospital Foundation staff and donors primarily come from non-medical backgrounds. Please bear this in mind when providing your responses to the questions that follow.

## Applicant Details

\* indicates a required field

### Primary Applicant \*

Title First Name Last Name

|                      |                      |                      |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|----------------------|

### Primary Applicant's Position \*

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**Primary Applicant HE Number \***

**Contact Phone Number (business hours) \***

Must be an Australian phone number.

**Mobile Phone Number**

Must be an Australian phone number.

**Phone Number (other)**

Must be an Australian phone number.

**CAHS Health Email \***

**Primary Email**

If different than above.

**Primary Applicant Previous Funding**

**Have you previously received funding from PCHF? \***

☐ Yes

☐ No

**If yes, what was the Grant ID Number and Title of your most recent application? \***

E.g. Grant 9000: Title of Grant.

**If yes, what is the status of your most recent grant funded by PCHF? \***

☐ Awarded, not yet  
commenced

☐ Funded, active

☐ Completed,  
acquitted

☐ Other:

**Co-Applicants**

**Do you have co-applicants? \***

☐ Yes

☐ No

**How many co-applicants do you have?**

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Must be a number.  
Maximum of 15 co-applicants per application form.

### Co-Applicant 1

**Co-Applicant**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

If applicable

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

### Co-Applicant 2

**Co-Applicant**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

### Co-Applicant 3

**Co-Applicant**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

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## Co-Applicant 4

**Co-Applicant**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

## Co-Applicant 5

**Co-Applicant 5**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant 5 Position**

What is your role in this project?

**Co-Applicant 5 Primary Email**

Must be an email address.

**Co-Applicant 5 Institution**

## Co-Applicant 6

**Co-Applicant**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

## Co-Applicant 7

**Co-Applicant**

| Title                | First Name           | Last Name            |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

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**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

Co-Applicant 8

|                     |       |            |           |
|---------------------|-------|------------|-----------|
| <b>Co-Applicant</b> | Title | First Name | Last Name |
|                     |       |            |           |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

Co-Applicant 9

|                     |       |            |           |
|---------------------|-------|------------|-----------|
| <b>Co-Applicant</b> | Title | First Name | Last Name |
|                     |       |            |           |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

Co-Applicant 10

|                     |       |            |           |
|---------------------|-------|------------|-----------|
| <b>Co-Applicant</b> | Title | First Name | Last Name |
|                     |       |            |           |

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Co-Applicant Position

What is your role in this project?

Co-Applicant Primary Email

Must be an email address.

Co-Applicant Institution

Co-Applicant 11

Co-Applicant

Title

First Name

Last Name

Co-Applicant Position

What is your role in this project?

Co-Applicant Primary Email

Must be an email address.

Co-Applicant Institution

Co-Applicant 12

Co-Applicant

Title

First Name

Last Name

Co-Applicant Position

What is your role in this project?

Co-Applicant Primary Email

Must be an email address.

Co-Applicant Institution

Co-Applicant 13

Co-Applicant

Title

First Name

Last Name

Co-Applicant Position

What is your role in this project?



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**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

Co-Applicant 14

| Co-Applicant | Title                | First Name           | Last Name            |
|--------------|----------------------|----------------------|----------------------|
|              | <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

Co-Applicant 15

| Co-Applicant | Title                | First Name           | Last Name            |
|--------------|----------------------|----------------------|----------------------|
|              | <input type="text"/> | <input type="text"/> | <input type="text"/> |

**Co-Applicant Position**

What is your role in this project?

**Co-Applicant Primary Email**

Must be an email address.

**Co-Applicant Institution**

## Project Details

\* indicates a required field

**Project Title \***

**What type of grant are you applying for? \***

Select the type that is most applicable to your project.

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**Does your grant have a mental health component? If yes please elaborate.**

Please elaborate on the specific mental health issues your project aim to address, how you plan to address those, the resources allocated to this and the expected outcome.

**Which CAHS Department or Ward is your project associated with? Please tick all that apply. \***

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Aboriginal Health                             | <input type="checkbox"/> Education and Training                   | <input type="checkbox"/> Medical Technology Management Unit      | <input type="checkbox"/> PCH  |
| <input type="checkbox"/> Adolescent Medicine                           | <input type="checkbox"/> Emergency Department                     | <input type="checkbox"/> Neonatology                             | <input type="checkbox"/> PGME   |
| <input type="checkbox"/> Allied Health                                 | <input type="checkbox"/> Endocrinology and Diabetes               | <input type="checkbox"/> Neurology                               | <input type="checkbox"/> Pharmacy                                       |
| <input type="checkbox"/> Anaesthesia and Pain Management               | <input type="checkbox"/> ENT                                      | <input type="checkbox"/> Neurosurgery                            | <input type="checkbox"/> Physiotherapy                                  |
| <input type="checkbox"/> Audiology                                     | <input type="checkbox"/> Environmental Services                   | <input type="checkbox"/> Nephrology                              | <input type="checkbox"/> Plastic Surgery                                |
| <input type="checkbox"/> Burns   | <input type="checkbox"/> Equipment and Consumables Service        | <input type="checkbox"/> NETS WA                                 | <input type="checkbox"/> Procurement Infrastructure Contract Management |
| <input type="checkbox"/> CAHS  | <input type="checkbox"/> Gastroenterology                         | <input type="checkbox"/> Neurology and Neurosurgery              | <input type="checkbox"/> Refugee Health Service                         |
| <input type="checkbox"/> CAMHS - Community                             | <input type="checkbox"/> Gender Diversity Service                 | <input type="checkbox"/> NICU - KEMH                             | <input type="checkbox"/> Respiratory Medicine                           |
| <input type="checkbox"/> CAMHS - Emergency Telehealth Service          | <input type="checkbox"/> General Paediatrics                      | <input type="checkbox"/> NICU - Ward 3B                          | <input type="checkbox"/> Rheumatology                                   |
| <input type="checkbox"/> CAMHS - Inpatient Unit 5A                     | <input type="checkbox"/> General Surgery                          | <input type="checkbox"/> Nursing Services                        | <input type="checkbox"/> Rural Health                                   |
| <input type="checkbox"/> CAMHS - Multisystemic Therapy                 | <input type="checkbox"/> Haematology and Oncology                 | <input type="checkbox"/> Nursing Research                        | <input type="checkbox"/> Simulation Team                                |
| <input type="checkbox"/> CAMHS - Pathways                              | <input type="checkbox"/> Hospice                                  | <input type="checkbox"/> Occupational Therapy                    | <input type="checkbox"/> Social Work                                    |
| <input type="checkbox"/> CAMHS - Touchstone                            | <input type="checkbox"/> Hospital in the Home (HiTH)              | <input type="checkbox"/> Oncology Ambulatory Care                | <input type="checkbox"/> Speech Pathology                               |
| <input type="checkbox"/> Cardiology                                    | <input type="checkbox"/> Immunisation                             | <input type="checkbox"/> Ophthalmology                           | <input type="checkbox"/> Systems Biology                                |
| <input type="checkbox"/> Cardiothoracic Surgery                        | <input type="checkbox"/> Immunology and Dermatology               | <input type="checkbox"/> Orthopaedic Surgery                     | <input type="checkbox"/> Telehealth Coordination                        |
| <input type="checkbox"/> Child and Family Engagement Service           | <input type="checkbox"/> Infrastructure and Facilities Management | <input type="checkbox"/> Orthotics                               | <input type="checkbox"/> Theatres/PACU/ CSSD                            |
| <input type="checkbox"/> Child Development Service                     | <input type="checkbox"/> Infectious Diseases                      | <input type="checkbox"/> Otolaryngology Head and Neck Surgery    | <input type="checkbox"/> Volunteer Coordination                         |
| <input type="checkbox"/> Child Health Research                         | <input type="checkbox"/> Infection, Prevention and Control        | <input type="checkbox"/> Paediatric Consultation Liaison Service | <input type="checkbox"/> Ward 1A  |
| <input type="checkbox"/> Child Protection Unit                         | <input type="checkbox"/> Information and Communication Technology | <input type="checkbox"/> Paediatric Critical Care                | <input type="checkbox"/> Ward 1B  |
| <input type="checkbox"/> Community Nursing North, South & Metropolitan | <input type="checkbox"/> Innovation                               | <input type="checkbox"/> Paediatric Nursing Education            | <input type="checkbox"/> Ward 2A  |
| <input type="checkbox"/> Day Treatment Unit (DTU)                      | <input type="checkbox"/> Kkind                                    | <input type="checkbox"/> Paediatric Rehabilitation               | <input type="checkbox"/> Ward 2B  |

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- |  |  |   |                                  |
|--|--|---|----------------------------------|
| <input type="checkbox"/> Dental                  | <input type="checkbox"/> Medical Illustrations | <input type="checkbox"/> Palliative Care          | <input type="checkbox"/> Ward 3C |
| <input type="checkbox"/> Dietetics               | <input type="checkbox"/> Medical Imaging       | <input type="checkbox"/> Patient Flow Unit        | <input type="checkbox"/> Ward 4A |
| <input type="checkbox"/> Eating Disorder Service | <input type="checkbox"/> Medical Services      | <input type="checkbox"/> Patient Support Services | <input type="checkbox"/> Ward 4B |

**If your department is not listed above, please include it here:**

**How many months do you expect this project will take to complete? See hints below for more information. \***

Must be a number.

Please take into consideration time taken to complete recruitment, obtaining and reporting on all final results, submission of all grant claims etc. Please also consider the time it will take to receive ethics approval, recruit subjects for studies, recruit for positions, recoup expenses, etc. as related to your project.

**Are there any specific time constraints associated with this project? \***

E.g. Project must start or end by a specified date. Please see the link to the "PCHF Grant Application Process" at the start of this application for details on the Foundation's funding process following grant award.

**If your application is approved, when do you expect to start your project following notification that funding has been secured for your grant? \***

E.g. Project expected to start within two months of funding notification to allow for recruitment time. Please note approved grants are not able to start until funds have been secured by PCHF. Notifications will be provided when the grants are awarded and subsequently when they are funded.

**Will the primary applicant be responsible for delivering the project, or will another CAHS staff member be the project lead? \***

Word count:

Must be no more than 100 words.

If the person responsible for the project is not the primary applicant, please describe how the project delivery and outcomes will be assured.

**Short Project Description \***

Must be no more than 200 words.

Provide a short description of how your project will transform the healthcare of children and young people in WA.

**What is the primary purpose of the equipment you are applying for? \***

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☐ Clinical

☐ Research

☐ Both clinical and research

☐ Other:

Please advise the status of the study in which you will be using this equipment \*

☐ Study has commenced

☐ Study has not yet commenced

☐ Other:

If the study has not yet commenced, what is the status of the funding for the study?

What is the status of obtaining the required ethics and governance approvals for the study? \*

- ☐ Ethics approval obtained
- ☐ Ethics approval not yet obtained
- ☐ Governance approval obtained
- ☐ Governance approval not yet obtained
- ☐ Not applicable
- ☐ Other:

If you have not yet obtained ethics and/or governance approval for the study, please advise on the status of those.

### Equipment Details

Please note, formal supplier quotations are required for all medical/research equipment, and requested for non-medical equipment where possible.

| What is the name of the equipment being requested? | If medical equipment, does this equipment have TGA approval? | Where will the equipment be stored and used? | Quote from supplier |
|--|--|--|---------------------|
|--|--|--|---------------------|

|  |  |  |   |
|--|--|--|---|
|  |  | Please specify the department or area within CAHS, CAMHS or CACHS where this equipment will be used in. If the equipment will be used outside of these facilities, please specify. | Please upload supplier quote(s) here that are in date at the time of application submission, ensuring prices listed are ex-GST and all freight, delivery, installation, and training costs are included. Please ensure quotes are in AUD, itemised and exclude discounts. |
|  |  |  |   |
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**Following delivery of the equipment, when do you expect it to be used for its intended purpose for the first time? Please include any equipment installation/implementation dependencies. \***

E.g. requested equipment will be used within 1 month following MTMU tagging of the equipment, noting MTMU tagging is likely to take approximately two weeks. Please consider any dependencies which could affect taking the equipment into use, such as needing to install software prior to use, training requirements for staff etc

**Have all relevant delivery, installation and training costs been included in the supplier quote provided? \***

☐ Yes ☐ No ☐ N/A

**Please provide details if cost have not been included in supplier quote provided.**

**Are any quotes provided in foreign currencies and/or is equipment being shipped from overseas? \***

☐ Yes ☐ No ☐ N/A

**Which currency was used for the quote and where is the equipment being shipped from? \***

**Noting that the amount of funding requested at the time of the application will the maximum funding awarded if the application is approved, how have you accounted for exchange rate fluctuations and any relevant customs duties? \***

## Research Details

**Are you applying as a New Investigator? \***

☐ Yes ☐ No

**Field of Research (Speciality) \***

**Is ethics required for this project? \***

☐ Yes ☐ No

Please note, if ethics is required and this application is approved by PCHF, receipt of ethics will be required prior to funds being released.

**If so, what is the Ethics Approval Status?**

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☐ Not Submitted

☐ Pending

☐ Approved

**If you have received ethics approval, please provide HREC number.**

Please advise the ethics approval number.

**If applicable, what date was ethics approval received?**

Must be a date.

**Is governance approval required for this project?**

☐ Yes

☐ No

**If so, what is the Governance Approval Status?**

☐ Not submitted

☐ Pending

☐ Approved

**If you have received governance approval, please provide the reference number.**

**If applicable, what date was governance approval received?**

Must be a date.

**Administering Institution \***

**Administering Institution Contact Officer**

Title

First Name

Last Name

Contact at administering institution.

**Position of Administering Institution Contact Officer**

**Administering Institution Contact Officer Email**

Must be an email address.

**If your research project will be administered by a non-CAHS entity, please upload a letter from CAHS authorising the project to be administered by the non-CAHS institution.**

Attach a file:

**If your research project will be administered by a non-CAHS entity, please upload a letter from the administering institution confirming their willingness to accept and administer the project.**

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Attach a file:

**Was biostatistics advice used for this application? \***

☐ Yes ☐ No

If yes, please respond to the below biostatistics questions.

**Biostatistician \***

Title First Name Last Name

**Biostatistician Institution \***

**Please attach a signed letter from Biostatistician confirming acknowledgement of advice provided in this application.**

Attach a file:

## Consumer and Community Involvement

**Have you sought advice from consumers/community members and/or other relevant stakeholders in the development of your project? \***

☐ Yes ☐ No

**Please tell us what you have done in relation to consumer, community, and/or other stakeholder involvement. \***

**Please tell us why consumer, community, and/or other stakeholder involvement has not been incorporated into the project at the time of the application. \***

**Do you intend to involve consumers and community members and/or other relevant stakeholders in your project once it begins? \***

☐ Yes ☐ No

**Please tell us about your plans to involve consumers, community members, and/or other relevant stakeholders in your project. \***

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**Please tell us why you will not be involving consumers, community members, and/or other relevant stakeholders in your project? \***

**New Question**

### Project Details (continued)

\* indicates a required field

#### The compelling need/problem

What evidence is there that the program, study, or service is needed to transform paediatric health in WA? Please state why the project cannot be funded by the Government? Please include the number of children/patients currently affected and the types of disease, illness, injury or conditions they face.

Any supporting documents referred to in this section can be uploaded at the end of the application.

**Please describe the paediatric health issue(s) your project will address in lay terms. \***

Word count:

Must be no more than 500 words.

#### The solution/proposed change

Briefly describe the main aims of your project and how it will address the identified paediatric health issue(s). Summarise what improvement is required and how your project will ensure this improvement can be made. Consideration should be given to how the project satisfies the Foundation's primary focus to promote the control and/or prevention of disease in children if applicable to your project.

Any supporting documents referred to in this section can be uploaded at the end of the application.

Note: If your application is for a research project, please describe the research question, hypothesis, and justify the proposed intervention. Please also detail how your proposed intervention will be implemented, including a description of the project design, method, and analysis plans.



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**How will your proposed solution effectively address the paediatric health issue(s) identified in your project in lay terms? \***

Word count:

Must be no more than 1200 words.

**What are the expected outcomes of the project in lay terms? \***

Word count:

Must be no more than 500 words.

**How will you know if these outcomes have been achieved? \***

Word count:

Must be no more than 300 words.

### The positive impact/benefits of making the change

Please describe the paediatric healthcare outcomes you anticipate the project will achieve in terms of positive differences for the child, adolescent, department, clinical practice at CAHS and/or paediatrics in general.

Any supporting documents referred to in this section can be uploaded at the end of the application.

**Please describe the positive impact (benefit) of making the change?**

Word count:

Must be no more than 250 words.

**Please describe how this project is innovative in paediatric health. \***

Word count:

Must be no more than 250 words.

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**How will you monitor and evaluate the project outcomes? Please include the specific measures you will use to inform your evaluations. Any supporting documents referred to in this section can be uploaded at the end of the application.**

Word count:

Must be no more than 250 words.

### Project Milestones

- *List the core activities that you will undertake to achieve your project outcomes and the anticipated time needed to achieve these milestones from project commencement.*
- *Please consider required approvals, data collection, analysis/, staff recruitment, participant recruitment, report preparation, equipment installation/training etc.*
- *All milestones should be included within the requested project period.*

#### Project Milestone

#### Anticipated Time Frame from Project Commencement

|  |   |
|--|---|
| Please add more rows as required to complete this section. | Please specify if length of time is calculated in months or years, and if it will be a recurring milestone (e.g. every 3 months from commencement). |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |

### Demonstrated Capacity to Undertake Project

Please detail risk mitigation strategies to ensure the project is delivered within the proposed structure and time frame, demonstrate adequate resourcing to deliver project, and/or describe similar projects that you successfully delivered in the past.

**How will you ensure your project is accomplished within your proposed time frame and format? \***

Word count:

Must be no more than 250 words.

### Project Collaborators

Please identify any anticipated project collaborators who are external to CAHS and will support the delivery of the planned project outcomes.

#### Name of person or organisation

#### Role in project

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### Project Details (continued)

\* indicates a required field

#### Quotable Comments

- Provide a short comment on the community need and/or proposed outcomes/benefits of the project from the relevant Executive Director, Delegated Authority, project lead, beneficiaries, and/or other approved spokesperson that can be used in proposals to potential donors and/or media releases and articles relating to the project.
- Note that the spokesperson/s may also be required to speak to media about the project should the grant application be successful.

**Please provide quotes below. \***

**Please attach the relevant consent form if a quote is provided from a patient/family and identifying information is included.**

Attach a file:

#### Case Stories

- Provide the names and contact details of the parents/carers of at least two patients who will benefit from this initiative.
- If you would like to include additional case stories or testimonials from families or project participants, please upload them at the end of the application in the Supporting Documents section.
- Case stories are the most demonstrative evidence used by the Foundation to inform donors of the difference they can make. The Foundation will contact the families you suggest in order to obtain case stories and photos that will be included in proposals to donors, used to publicise the work of the Foundation and assist in attracting future donors.
- Please ensure a consent form signed by the legal guardian of the patient are provided with any patient details listed below. Please only include details of families who are agreeable to being contacted by the Foundation for further information if required.
- If you are not able to provide case stories now, please confirm below your commitment to providing these details upon request from PCHF following project commencement.

**Have you provided case stories below? \***

- ☐ Yes
- ☐ No, I will provide them upon request from PCHF following project commencement
- ☐ CAHS staff are the beneficiaries and can provide quotes upon request

# PCHF FY24 Annual Grants Application Form

## Form Preview

**Name of patient #1**

First Name

Last Name

**Date of birth of patient**

Must be a date.

**Brief summary of patient's condition and how they would benefit from this initiative****Name of parent/carer**

First Name

Last Name

**Parent/carer mobile phone number**

Must be an Australian phone number.

**Parent/carer home phone number**

Must be an Australian phone number.

**Consent form for patient #1**

Attach a file:

Form to be signed by patient's legal guardian.

**Name of patient #2**

First Name

Last Name

**Date of birth of patient**

Must be a date.

**Brief summary of patient's condition any how they would benefit from this initiative****Name of parent/carer**

First Name

Last Name

# PCHF FY24 Annual Grants Application Form

## Form Preview

### Parent/carer mobile phone number

Must be an Australian phone number.

### Parent/carer home phone number

Must be an Australian phone number.

### Consent form for patient #2

Attach a file:

Form to be signed by patient's legal guardian.

## Hi-Res Images, Headshots and Videos

- Images, headshots, and videos are used to show potential donors what they may be able to help fund, which may decrease the time for an approved project to be funded. Files provided may also be used on social media, websites, annual reports, etc.
- It is strongly recommended that you include at least one image or video relevant to your project to accompany your application e.g. equipment, photo of child using equipment, photo of patient who would benefit from project, staff member(s) involved in project, etc.
- Please ensure permission from individuals featured or suppliers are captured as photos and videos may be shared with prospective donors and the public. Consent forms obtained should be uploaded below.

### Images, headshots and/or videos

### File description

### Consent form (if applicable)

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
| Please ensure images are high resolution e.g. 600 dpi or greater in either jpeg or PDF format. |  |  |

## Acknowledgement Opportunities

### Please tick all opportunities for acknowledgement/engagement of PCHF and donors that may apply to your project. \*

- |   |  |
|---|--|
| <input type="checkbox"/> In media articles            | <input type="checkbox"/> Supporter/s logo placement e.g. on equipment            |
| <input type="checkbox"/> On websites                  | <input type="checkbox"/> Naming rights e.g. title of fellowship, equipment, etc. |
| <input type="checkbox"/> In publications              | <input type="checkbox"/> Special project impact presentation to supporters       |
| <input type="checkbox"/> On promotional materials     | <input type="checkbox"/> At donor events   |
| <input type="checkbox"/> At presentations/conferences |  |

# PCHF FY24 Annual Grants Application Form

## Form Preview

**Please share any additional opportunities for acknowledgement/engagement of PCHF and donors related to your project.**

Please ensure to include any media opportunities if relevant.

## Budget

\* indicates a required field

### Project Budget

To review the PCHF Grant Application Guidelines and what can/cannot be funded, please click [here](#).

For budget items related to staff salaries, please ensure you include the person's name (if known), salary, on-costs, position, level, and time period.

| Description of budget items you are requesting PCHF to fund                | Cost of budget item in AUD and ex-GST         | Description of budget items to be funded by other funding sources | Cost of budget item in AUD and ex-GST        |
|--|---|---|--|
| E.g. salaries, equipment, consumables, data analytics, on-costs rates etc. | Please ensure all items are listed as ex-GST. | E.g. gifts in kind, items to be funded by other funders           | Please ensure all items are listed as ex-GST |
|  |   |   |  |
|  | \$  |   | \$   |
|  | \$  |   | \$   |
|  | \$  |   | \$   |
|  | \$  |   | \$   |
|  | \$  |   | \$   |
|  | \$  |   | \$   |

**Total Amount of Funding Requested \***

\$

This number/amount is calculated.  
This is the sum of the expense items listed in Column 2 in the above table.

**Total Project Cost**

\$

This number/amount is calculated.  
This is the total budgeted cost of your project based on the above table.

**Were any formal quotes for budget items listed above provided in a foreign currency? \***

☐ Yes

☐ No

☐ N/A

**If yes, which currency was used for the quote? Please ensure all figures provided in the budget table above are in AUD and ex-GST. \***

# PCHF FY24 Annual Grants Application Form

## Form Preview

**Noting that the amount of funding requested at the time of the application will be the maximum funding awarded if the application is approved, how have you accounted for exchange rate fluctuations and any relevant customs duties? \***

**Have you applied to other funding sources for this project? \***

☐ Yes

☐ No

### Other Confirmed Funding Sources

### Amount of Funding Received

|  |                          |
|--|--------------------------|
| Please list names of other funding sources you have secured funding from for your project. | Must be a dollar amount. |
|  | \$                       |
|  | \$                       |
|  | \$                       |

### Total Confirmed Other Funding

\$

This number/amount is calculated.

### Other Unconfirmed Funding Sources

### Amount of Funding Requested

|   |                          |
|---|--------------------------|
| Please list names of other unconfirmed funding sources e.g. other funding sources you have applied to for funding for your project. | Must be a dollar amount. |
|   | \$                       |
|   | \$                       |
|   | \$                       |

### Total Unconfirmed Other Funding

\$

This number/amount is calculated.

## Supporting Financial Documents

**Please upload supporting financial information if required. Please note that quotes provided should be valid at the time of submission and for at least 30 days thereafter**

Attach a file:

E.g. quotes from suppliers, other funding award documentation, etc.

## Anticipated Claims Schedule

Please provide an anticipated claims schedule from the start date of the project. Please note the Foundation's preference is for quarterly claims in arrears.

# PCHF FY24 Annual Grants Application Form

## Form Preview

Considerations should be made regarding timing of project (e.g. staff/participant recruitment, ethics approval, invoice processing times, delivery of equipment etc.) to ensure that proposed schedule is as realistic as possible.

Applicants applying for equipment to be procured in one purchase should put Quarter 1 and the full value of the equipment; if equipment will be procured/purchased over a period of time, please fill out the table according to the anticipated claims schedule.

| Time Frame                          | Total Anticipated Claim Amount |
|-------------------------------------|--------------------------------|
| E.g. Quarter 1 or Year 1 of project | Must be a dollar amount.       |
|                                     | \$                             |
|                                     | \$                             |
|                                     | \$                             |
|                                     | \$                             |
|                                     | \$                             |

## Claims Schedule Dependencies

**Please provide commentary here if there are dependencies within your project that may impact your anticipated claims schedule. E.g. staff recruitment, production times, etc.**

## Additional Information

### Supporting Documents

If you have any supporting documents you referred to earlier in your application please upload them here. Supporting documents may include, but are not limited to, reference lists, tables, diagrams, patient/participant testimonials, consent forms, etc.

#### File Description

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |

## Comments

**Are there any other pertinent/relevant comments or information you would like to make about your application?**

## Conditions and Approvals

\* indicates a required field



# PCHF FY24 Annual Grants Application Form

## Form Preview

### Conditions

Please note the below conditions must be agreed to by the primary applicant if funding is awarded.

**The primary applicant agrees to provide additional contact details of patients/families or project participants who will benefit from the project so they can be approached for their story to be included in funding proposals to potential donors should those noted above not be suitable or available. \***

☐ I agree

☐ I do not agree

**The primary applicant agrees to review drafts of written material to be used by the Foundation to promote fundraising for the project. \***

☐ I agree

☐ I do not agree

**The primary applicant agrees to facilitate and host ward/department tours for donors. \***

☐ I agree

☐ I do not agree

**The primary applicant agrees to attend and speak at thank you presentations with donors. \***

☐ I agree

☐ I do not agree

**The primary applicant agrees to participate in media and other publicity activity around the project and/or provide other members of hospital/health service staff to participate in such activity. \***

☐ I agree

☐ I do not agree

**The primary applicant agrees to acknowledge Perth Children's Hospital Foundation and the donor through placement of an equipment tag and/or Department wall plaque and/or logo on any printed material related to the project. \***

☐ I agree

☐ I do not agree

**The primary applicant agrees to acknowledge the Foundation as the source of the funding in media articles and publications related to the project. \***

☐ I agree

☐ I do not agree

**I agree that all claims submitted to PCHF will be authorised by myself as the primary applicant.**

☐ I agree

☐ I do not agree

**The primary applicant agrees to provide a report outlining outcomes of the project as directed by the award letter if this application is successful. \***

☐ I agree

☐ I do not agree

### Confirmation

Please confirm the below:

# PCHF FY24 Annual Grants Application Form

## Form Preview

**I, the primary applicant, confirm I have read and understood the Funding Guidelines at the start of this application. \***

☐ Yes

☐ No

**I, the primary applicant, confirm that my project falls within the funding guidelines. \***

☐ Yes

☐ No

**I, the primary applicant, confirm that the project is not for the purpose of replacing core equipment used in the day-to-day operation of the Department/Ward. \***

☐ Yes

☐ No

## Key CAHS Contacts

Please list the key CAHS contacts below as relevant to your project.

### Primary Applicant

Title

First Name

Last Name

### Head of Department/Service Manager

Title

First Name

Last Name

### Divisional Director/Co-Director

Title

First Name

Last Name

### Executive Director

Title

First Name

Last Name

### Chief Executive

Title

First Name

Last Name

**IMPORTANT:** Please ensure your application is complete prior to doing this step.

Please download the [Application Endorsement Form here](#), collect relevant signatures and upload the completed form below. Prior to uploading, the form will need to be signed by the relevant Delegated Authority or Service Manager for all applications. For applications requesting funding for \$150,000 or above, the form will also need to be signed by the CAHS Chief Executive.

**Filling out the form:**

# PCHF FY24 Annual Grants Application Form

## Form Preview

You can download and print the form to complete it as a hardcopy, or you can open it with Adobe Reader DC, if you wish to complete it electronically. Just download and save the form, open it with Adobe Reader DC, select Fill & Sign on the right hand side to enter information, and once ready to sign, select the Sign option at the top of the pdf page.

**\*Please note,** we accept both wet and electronic signatures on the Application Endorsement Form, however signatures must be an original, personal signature in both cases. As such, we do not accept typed names or "HE numbers" in lieu of a signature.

### **Please upload your signed Application Endorsement Form \***

Attach a file:

The form is available to download via the link above. Please call the PCHF Grants team on 6456 5550 if you require any assistance .

### **Please upload any other relevant letters of endorsement**

Attach a file:

By submitting this application and providing the attached Application Endorsement Form, the primary applicant confirms that they have the authority and all the necessary approvals from CAHS to undertake and deliver the proposed project if approved for funding by PCHF.