health

Department:
Health
PROVINCE OF KWAZULU-NATAL

APPLICATION FOR GRANT FUNDING TO HEALTH INSTITUTIONS

COMPLETED APPLICATIONS TOGETHER WITH SUPPORTIVE DOCUMENTATION MUST BE SUBMITTED TO THE RELEVANT DISTRICT OFFICE AND MUST BE ADDRESSED AS FOLLOWS:-

APPLICATION FOR GRANT FUNDING

THE DISTRICT MANAGER

DISTRICT: ________________

DEPARTMENT OF HEALTH – KWAZULU-NATAL

Application is herby made for grant funding for subsidized health services by the KZN Department of Health, details of which are supplied below.

1. Details of Applicant:

1.1 Name of Health Institution:

____

____

1.2 Physical address:

____

____

____

1.3 Postal address:

____

____

____

1.4 Contact Numbers:

Office: ______________________________

Fax: ______________________________

Mobile: ______________________________

Other: ______________________________

1.5 Email Address:

____

1.6 Banking details: (Original stamped letter from the bank must be attached)

Name of Account Holder: ______________________________

Bank: ______________________________

Account Number: ______________________________

Branch Code: ______________________________

Account Type ______________________________

1.7 Name, position and contact details of contact person:

____

____

____

____

2. District in which facility is situated (indicate with a tick):

Ugu		eThekwini		Ilembe		Umgungundlovu	
Uthukela		Amajuba		Sisonke		UMzinyathi	
UMkhanyakude		Uthungulu		Zululand			

3. State category of not for profit organizations (indicate with a tick):

Voluntary Association ☐

Section 21 company ☐

Trust ☐

Other___________________ ☐

4. Registration number of the Not for Profit Organization.

____

5. List the names and Identity numbers of the board members and / or the trustees:

____

____

____

____

6. Indicate which broad category the establishment falls into (indicate with a tick):

6.1 Clinic/hospital

- Primary Health Care and Health Promotion ☐
- Child Health, especially nutrition and development; ☐
- Prevention of HIV & AIDS and support to people infected and/ or affected by HIV
- & AIDS, including treatment support; ☐

- Youth and Adolescent Health; ☐
- Reproductive Health Services, including during pregnancy and post birth ☐
- Prevention of Blindness and Eye Care ☐
- T.B. Identification and Care ☐
- Palliative Care / Step Down ☐
- Inpatient Care ☐
- Mobile clinics ☐
- Home Based Care ☐
- Other ____ ☐

6.2 Step-down Care

- Rehabilitation and Disabilities. ☐
- Palliative Care / Step Down ☐
- Inpatient Care ☐
- Home based care ☐
- Other ____ ☐

6.3 Mental Health

- Rehabilitation and Disabilities. ☐
- Mental Health, including day & residential care, and Substances Abuse ☐
- Other ____ ☐

7. Provide detailed information on each service provided?

____

____

____

____

____

____

(Use separate sheet if necessary)

8. State number of usable beds / clients where applicable

- Number of beds: ☐
- Number of Clients: ☐
- Other: ____________________ ☐

9. What is the extent of the present demand for the services that is being provided?

____

____

(Use separate sheet if necessary)

10. Provide a map indicating the catchment area as well as an indication of all other health care establishments (public and private) in the catchment area.

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11. Provide detailed reasons as to why funding should be considered.

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____

(Use separate sheet if necessary)

12. Attach a copy of your 3 Year Business plan (Compulsory)
The business plan must include the total amount of funds applied for each year as well as a detailed budget for each year.

13. Number of staff employed.

	FULL TIME	**PART TIME**
Medical		
Pharmacist		
Dental		
Physiotherapist		
Occupational therapist		
Speech therapist		
Audiologist		
Councilors		
Other		
NURSING STAFF		
Registered Professional		
Student (Registered)		
Enrolled Nurse		

	FULL TIME	PART TIME
Enrolled Pupil		
Enrolled Assistant		
Enrolled Pupil Assistant		
Home based care giver		
Other		
SUPPLEMENTARY HEALTH SERVICES PERSONNEL		
Management		
Administrative Personnel		
General Assistants		
Maintenance Staff		
Security		
Driver		
Kitchen Staff		
Garden staff		
Other		

14. Funding:

14.1 Is this facility receiving funding from any other source?

Yes	No

14.2 If “Yes”, give details of the funding and the amount:

____

____

____

____

15. Give details of any other information deemed necessary for this application with supporting documents to guide the adjudication of this application for funding.

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____

(Use separate sheet if necessary)

16. Please attach the resolution of the Board/Trustees authorising the person to sign/act on behalf of the organization.

I hereby certify that the above particulars are true and correct.

Name: ….. Signature: …………..

Position held: .... Date: ....

FOR OFFICE PURPOSES ONLY

Recommended / Not Recommended

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____
____

____

District Manager

District: ___________________

Date: ___________________

Supported / Not Supported

____
____
____

____

Pre Approval Committee

Date: ___________________

Approved / Not Approved

____

Head of Department

Date: ___________________

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