Application for Global Partnerships

Global Partners in Care will make every effort to partner organizations appropriately and as quickly as possible. Once we receive your complete application, we will be in contact with you to discuss the next steps. We seek to partner organizations who have a significant focus on the provision or support of palliative and hospice care. Applicants should ensure that they provide brief overview of their work in palliative and hospice care in section 2.

1. General Information: Date:

Name of Organization:

Address:

City:

State/Province/ Region:

Country:

Telephone:

Fax:

Website:

Contact Person*:

Title of Contact:

Primary Contact's Telephone:

Primary Contact's Email:

Secondary Contact Person:

Title of Secondary Contact:

Secondary Contact's Telephone:

Secondary Contact's Email:

**Contact indicates individual at your organization who will be the primary contact for Global Partners in Care.*

2. Organizational Information:

a. What is your organization's Mission Statement?

b. What palliative and/or hospice care services are currently offered in your organization?

Do you have an inpatient facility?	☐ Yes	☐ No
Do you provide home-based care?	☐ Yes	☐ No
Do you provide community-based care?	☐ Yes	☐ No
Do you provide pediatric palliative/hospice care?	☐ Yes	☐ No

Please share additional information regarding your palliative and/or hospice care services.

c. If you do not provide palliative and/or hospice care services, please explain how are you engaged in supporting palliative and/or hospice care?

d. How long has your organization been in operation?

e. Program Type/ Agency Ownership:

- ☐ Free-standing/ Independent Hospice
- ☐ Part of a hospital system
- ☐ Part of a Home-based Care Program
- ☐ Other:

f. GPIC has a preference for partnering organizations that belong to a national association. Please explain any affiliation (or lack thereof) with another organization or parent organization:

g. Please complete the following: (utilize most recent data available)

- ❖ Number of Board Members
- ❖ Budget size in local currency
- ❖ Number of full-time staff
- ❖ Number of part-time staff
- ❖ Number of Volunteers
- ❖ Average Daily Census

h. Service area description: ☐ Urban ☐ Rural ☐ Mixed

i. Our patients are: ☐ Entirely inpatient ☐ Mostly inpatient ☐ Entirely outpatient ☐ Mostly outpatient ☐ Even mix of inpatient/ outpatient

j. What medicines does your organization use for pain management?

k. Does your organization have an annual audit? ☐ Yes ☐ No

If no, how does your organization account for funds received and spent?

Good communication is essential to strong partnership. GPIC requires a minimum communication of quarterly check-ins with us and between partners.

l. Does your organization have regular access to internet and email? ☐ Yes ☐ No

m. Please share any additional comment on your ability to maintain regular communication.

n. N/A for partners from the U.S. Does your organization have a bank account that is able to receive donations from the US? ☐ Yes ☐ No

o. Please share any additional information on known restrictions or challenges to receiving funds from the US.

3. Interest in Partnering:

a. How did you hear about Global Partners in Care?

b. Is your program currently partnered with a palliative / hospice care organization in another country? ☐ Yes ☐ No

If YES, please describe:

c. What are the main sources of funding for your organization?

d. What are your objectives in entering a partnership? Please be as specific as possible.

e. What are your expectations of a partner in entering into a global partnership?

4. Signature:
Signature of person authorized by the organization to legally enter into Agreements.

Signature: _____ Date: _____

Please return your application to:

Mail: Global Partners in Care
501 Comfort Place
Mishawaka, IN 46545 USA
E-mail: info@globalpartnersincare.org

Thank you for your interest in becoming a Partner with Global Partners in Care!

RECEIVED BY: (Global Partners in Care staff to complete)

Name **Date**