International Partnering Agency Application

Applicant/Organization Making The Request
1. Agency's Full Legal Name:
2. Web Site:
3. Date of Program Establishment:

NGO Verification *(please check only one)*	
☐	This agency is a 501(C)3 organization that is not a privately funded foundation or municipality ***(please attach a copy of your 501(c)3 letter)***
☐	This agency does not have a NGO. ***Please explain:***

Contact Information			
	US Primary Contact	**US Secondary Contact**	**In-Country Primary Contact**
Contact Name			
Shipping Address			
Position			
Phone			
Cell Phone			
Email			

In-Country Program Information
1. Primary Site Name if different from Organization Name:
2. Please indicate the program type for which your organization will utilize resources from Matter *(Please check all that apply).*
☐ **School** ☐ **Hospital/Clinic** ☐ **Orphanage** ☐ **Other (specify) _____**

3. Describe the percentage of the following population served:

___% women ___% men ___% elderly ___% children

4. Site Address (or final destination where the shipping container will be delivered):

5. Please provide a narrative outline of your program (attach separate sheet if more space is needed):

6. Please describe how Matter's resources will be used and geographic area served:

7. Please indicate percentage of funding for your program *(complete all that apply):*

Client Fees _____ % Grants _____ % Benevolence Fund _____ %

Private Donations _____ % Government Funds _____ % Fund Raisers _____ %

Other *(please specify):* _____

8. Please list other agencies from whom you receive support (materials & resources, not funding - use additional sheet if necessary):

Other Information
1. How did you hear about Matter? **2. Please provide any other relevant information you may wish to share to help us determine whether a partnership with your organization would be a good fit for Matter**.

Return completed form to:

Matter
Attn.: Jeremy Newhouse
7005 Oxford Street
St. Louis Park, MN 55426

Jeremy@MatterMore.org

Please make sure to include:

- ✓ Completed International Partnering Agency Application
- ✓ Copy of your 501(c)(3) letter
- ✓ Completed Hospital or Program Evaluation

Matter office use only

Date received: _____
By (print): _____
Approved: yes no

MATTER
FOR ALL IT'S WORTH

Hospital/Clinic Evaluation

The following is a self-assessment tool for hospitals and clinics that wish to avail themselves of the services of Matter. The evaluation should be completed by those most closely associated with the department or area of the hospital/clinic in question.

Please be as specific as possible. If there are departments that are overlapping when using equipment of staff, please specify in the narrative portion. Please feel free to note anything that is of significance or is specific to your facility. You may enclose an addendum at the end of the evaluation.

The evaluation is intended to cover ALL potential partners. We are aware that there may be categories which may not pertain to your situation. Complete non-applicable fields as "N/A".

Please answer each of the five sections to ensure that we will provide you with equipment that best matches your needs.

Part 1: Staffing

Please tell us about the staff you have available in your program. Please indicate full-time or part-time staff.

POSITION	QUANTITY	FULL-TIME	PART-TIME
PHYSICIANS			
NURSES			
MIDWIVES			
PHYSICIANS ASSISTANTS			
ADMINISTRATION			
LAB TECHNICIANS			
MAINTENANCE			

Part 2: Current Equipment Inventory

Please list by department the equipment currently available. Indicate by checking the checkbox next to the item if these items need to be replaced.

Emergency	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Critical Care	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Intensive Care	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Obstetrics	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Gynecology	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Pediatrics	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐

Orthopedics	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Medical & Surgical Floors	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Laboratory / Pathology	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Operating Room	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Cardiology	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Imaging	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐

Part 3: Equipment Wish List

Please list by department the equipment you want for your project. Please reference the accompanying "Menu of Services" form to get a better understanding of the items that Matter typically ships in a container.

Use the checkbox to grade each item's importance: 1) Do not ship the container without this item, 2) Important item that is useful for our project, 3) Include this item if there is room in the container.

Please be sure to include items you need – even if they are not on the “Menu of Services” form - and we will to our best to find them.

Emergency	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Critical Care	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Obstetrics	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Gynecology	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Pediatrics	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Medical & Surgical Floors	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ ☐ _____ ☐

Laboratory / Pathology	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Operating Room	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Cardiology	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐
Imaging	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐	• _____ ☐ • _____ ☐ • _____ ☐ • _____ ☐

Part 4: Physical Plant and Power

Please outline power supply *(circle YES or NO)*:

Is your power supply 220v?	YES NO If yes, please include a photo and/or diagram of your electrical (male) plug receptacle.
Is your power supply 50/60 Hz?	YES NO
Is your power supply 60 Hz?	YES NO
Are you able to use equipment that is 110v?	YES NO
Do you have surge protection?	YES NO
Is your electrical service municipal?	YES NO
How many hours per day do you have electricity?	

Do you experience power outages?	YES NO If yes, how often? _____
Do you experience brown outs or periods of decreased power that cause the lights to flicker or dim?	YES NO If yes, please explain:
Do you have a backup generator set?	YES NO If yes, how many KW-KVA? _____
Are you able to find fuses?	YES NO
Are you able to find replacement bulbs? **Are you able to find replacement batteries?**	YES NO YES NO
Do you have access to an electrician?	YES NO
Do you have a way to convert 110v 60 Hz to 220v?	YES NO
Do you have staff to calibrate and maintain electronics?	YES NO If yes, are they on your staff or are they contractors?
How many rooms are in your facility?	

Please include a drawing or schematics. Indicate what departments or services are housed in each section.

Part 5: Program Questions

Please answer this short questionnaire about the extent of you program and the services you intend to provide or currently provide.

Does your facility provide ongoing treatment of the critically ill and injured?	YES NO If yes, please provide a brief description:

What is the nurse to patient ratio in critical care?	
Do you use intravenous pumps?	YES NO
Do you do other types of advanced imaging?	YES NO Please explain in detail:
Do you have a 24hr Lab?	YES NO
Do you have EKG?	YES 12 Lead *or* Lead 2 NO
Do you perform Blood Gas Analysis?	YES NO
Do you deliver by Caesarian section?	YES NO
Do you transfuse on the Obstetrical floor?	YES NO

When returning this completed evaluation form to Matter, please remember to include:

- ✓ ***Photo and/or diagram of your electrical (male) plug receptacle for the 220V power supply***
- ✓ ***Drawing/schematics of your facility (indicate department/service names for each section)***