MATTER

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. Total number of patients served annually:

_____ adults _____ children

4. Total number of mothers and newborns served annually:

_____ mothers _____ newborns

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

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

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

8. 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):* _____

9. 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.: Katie Schlangen
7005 Oxford St.
St. Louis Park, MN 55426

Katie@matter.ngo

Please make sure to include:

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

MATTER

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/Role	***Quantity***	***Full-Time***	***Part-Time***
Physicians			
Nurses			
Midwives			
Physicians Assistants			
Lab Technicians			
Administration			
Maintenance			

Part 2: Patient Services

Please tell us about the patient services provided as well as patient census information:

Item	***Quantity***	***Item***	***Quantity***
Population Served		Average length (in days) of in-patient stay	
Mortality Rate (annually)			
Patient: Physician Ratio		Surgical Infection Rate (annually)	
# of Beds		Surgeries/ Month	
# In-Patients/ Month		# of Maternal Deaths/ Month	
# Out-Patients/ Month		# of Pre-Mature babies/ Month *weighs less than 2,500 grams	
Births/ month		# of Infant Deaths / Month	
C-Sections/ Month		Ultrasound Procedures/ Month	

Part 3: Current Equipment Inventory

Please list by department the equipment currently available.

Emergency	1.	**Orthopedics**	1.
	2.		2.
	3.		3.
	4.		4.
Critical Care	1.	**Surgical/ Medical Floor**	1.
	2.		2.
	3.		3.
Intensive Care	1.	**Laboratory / Pathology**	1.
	2.		2.
	3.		3.
	4.		4.
Obstetrics	1.	**Operating Theatre**	1.
	2.		2.
	3.		3.
	4.		4.
Gynecology	1.	**Cardiology**	1.
	2.		2.
	3.		3.
	4.		4.
Pediatrics	1.	**Imaging**	1.
	2.		2.
	3.		3.

Part 4: Equipment Needs

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 box to grade each item's importance:

Rank 1-3

1-Highest Priority

2- High Priority

3- Desirable

Please be sure to include ALL items you need – even if they are not on the "Menu of Services" form - and we will to our best to find them. Feel free to use another sheet of paper if necessary.

Emergency	1.		**Orthopedics**	1.	
	2.			2.	
	3.			3.	
Critical Care	1.		**Surgical/ Medical Floor**	1.	
	2.			2.	
	3.			3.	
Intensive Care	1.		**Laboratory / Pathology**	1.	
	2.			2.	
	3.			3.	
Obstetrics	1.		**Operating Theatre**	1.	
	2.			2.	
	3.			3.	
Gynecology	1.		**Cardiology**	1.	
	2.			2.	
	3.			3.	
Pediatrics	1.		**Imaging**	1.	
	2.			2.	
	3.			3.	

Part 5: Physical Plant and Power

Please outline power supply *(circle YES or NO)* and fill in the appropriate information where necessary:

Is your power supply 220v?	YES **If yes**, please include a photo and/or diagram of your electrical (male) plug receptacle.	NO
Is your power supply 50/60 Hz?	50Hz	60HZ
Do you have a voltage regulator?	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?	**How many rooms are in your facility?**	
Do you experience power outages?	YES **If yes**, how often?	NO
Do you experience brown outs or periods of decreased power that cause the lights to flicker or dim?	YES **If yes**, please explain:	NO
Do you have a backup generator set?	YES If yes, how many KW-KVA?	NO
Are you able to find fuses?	YES	NO
Are you able to find replacement bulbs?	YES	NO
Are you able to find replacement batteries?	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 If yes, are they on your staff or are they contractors?	NO

Part 6: 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**
What advanced imaging is provided?	**YES** **NO** **Please explain in detail:**
Do you have a 24hr Lab?	**YES** **NO**
Do you have EKG?	YES NO **If yes**, 12 Lead *or* Lead 2
Do you perform Blood Gas Analysis?	YES NO
Do you have a malnutrition center for children at the hospital?	YES NO **Please explain in detail-** how many children per month?:
Do you transfuse on the Obstetrical floor?	YES NO

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

- ✓ ***Photos*** *of each room where equipment will be placed*
- ✓ ***Drawing/blueprints of your facility*** *(indicate department/service names for each*