Expression of Interest - Application Form

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| Supporting Chronic Pain and Smoking Management in General Practice through Shared Medical Appointment Grants |

Note**:** The evaluation panel may include both internal and external members and no assumption should be made about familiarisation with your practice demographic, capability, or suitability. Kindly provide as many details as necessary to assist the panel in their assessment of your application.

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| **Section A – Organisation Information** | | | | | | |
| **Organisation name:** |  | | | | | |
| **ABN: (Required)** |  | | **Is the organisation registered for GST?** | |  | **Yes** |
|  | **No** |
| **Organisation address:** |  | | | | | |
| **Town:** |  | | **Postcode:** |  | |
| **rganisation phone:** |  | | | | | |
| **Key contact person:** | **Name:** | |  | | | |
| **Position in organisation:** | |  | | | |
| **Email:** | |  | | | |
| **Mobile phone:** | |  | | | |

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| **Section B – Assessment Criteria** |
| 1. **Workflow Model (700 words max) 35%** |
| *Provide a brief description of your proposed workflow model including the following key components:*   * How you will incorporate SMAs into your current workflow * Suitable location identified to run group sessions * Practice improvement opportunities identified * Capacity to support staff training in SMAs and new workflow processes * Previous experience implementing practice change initiatives |
| *Please provide your response here:* |
| 1. **Identify patient cohorts (500 words max) 25%** |
| *Provide a brief outline of your systems to identify patient cohorts in line with eligibility criteria noted in the scope and specifications including:*   * How you will **identify** and **engage** patients suitable for the *Chronic Pain Self-Management* and/or *Smoking Management* SMA program/s * Estimated number of patients in the practice who would be suitable for the *Chronic Pain Self-Management* SMA program or *Smoking Management* SMA program |
| *Please provide your response here:* |
| 1. **Roles and responsibilities (500 words max) 25%** |
| *Provide an overview of the proposed roles and responsibilities for the initiative, including:*   * Details of which staff will be responsible (i.e. GP/s responsible for SMA consultations, staff responsible for group facilitation, other staff involved). * Details of existing clinical governance and incident management arrangements including relevant policies and procedures. |
| *Please provide your response here:* |
| 1. **Aboriginal cultural safety (500 words max) 15%** |
| *Provide a brief outline of:*   * What steps you are taking to ensure your practice is safe and appropriate for Aboriginal and Torres Strait Islander people |
| *Please provide your response here:* |

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| **Section C – Compliance** | | | |
| 1. **Estimation of cost** | | | |
| **Provide an indicative budget for financial year(s) on the budget template provided (Attachment 2). Ensure the budget:**   * Supports the roles and responsibilities described | | Budget attached |  |
| **Provide copies of your accreditation certificates.** | | Current accreditation attached |  |
| **Provide required insurances attached including:** | |  |  |
| * Public liability insurance: Certificate of currency - $10 million per claim and in the aggregate of all claims | | Public liability attached |  |
| * Professional indemnity insurance: Certificate of currency - $5 million per claim and in the aggregate of all claims | | Professional indemnity attached |  |
| * Workers compensation as required by the law | | Workers compensation policy attached |  |
| * Cyber Security insurance – at least $1 million in all aggregate (optional) | | Cyber Security attached |  |
| **Referees**  **Include two (2) professional referees for new funding recipients.**  ***Practices who have previously received funding are not required to provide a referee.*** | | | |
| **Referee 1 Name:** |  | | |
| Position: |  | | |
| Organisation: |  | | |
| Email: |  | | |
| Phone: |  | | |
| **Referee 2 Name:** |  | | |
| Position: |  | | |
| Organisation: |  | | |
| Email: |  | | |
| Phone: |  | | |

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| **Section D– Declaration** | |
| ***This must be completed by an authorised representative of the organisation submitting the application:*** | **Agree** |
| I declare that the organisation is able to implement the project within the designated time frame (12-month period until July 2025). |  |
| I can confirm that the contents of this application are to the best of my knowledge accurate, complete and do not contain any false, misleading or deceptive misrepresentation, claims or statements. |  |
| I declare that funding has not been sought or received for this activity from any other source. |  |
| I declare that the organisation is financially viable and able to manage the funding within the timeframe and within budget. |  |
| I understand and accept that information provided in this application may be stored by COORDINARE – South Eastern NSW PHN in various hardcopy and/or electronic formats. |  |
| I understand that this application does not create a legal or binding commitment and that if successful I will be bound by a contract with COORDINARE - South Eastern NSW PHN. |  |
| I understand that I am required to have current and adequate insurances in place. |  |
| If this application is successful, I agree to provide reports in the specified format to  COORDINARE – South Eastern NSW PHN on activity processes and outcomes. |  |
| I understand that if the conditions of the funding are not complied with, COORDINARE – South Eastern NSW PHN may seek to recover any funds allocated. |  |

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| **Authorised Representative Name:** |  | **Date:** |  |
| **Position of Authorised Representative:** |  | | |
| **Authorised Representative Signature:** | *[e-signature is accepted]* | | |