Expression of Interest - Application Form

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

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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 (500 words max) 35%** |
| *Provide a brief outline 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 * 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. * Experience working with chronic pain patients. |
| *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. group facilitation, GP consultations) * 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:** |  | | |