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%**
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| *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%**
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| *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%**
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| *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%**
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| *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
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| *Please provide your response here:* |

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| **Section C – Compliance** |
| 1. **Estimation of cost**
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| **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:** |  |