Expression of Interest - Application Form

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| Collaborative Commissioning SENSW  Chronic Obstructive Pulmonary Disease (COPD) |

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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. **Outline your approach to delivering the designed care pathway (500 words max) - 35%** |
| *Please provide your response here:* |
| 1. **Demonstrate your operational and technical capacity, capability and experience in successfully delivering initiatives, including who will lead the initiative, how you have implemented new systems and processes, and how you will increase practice nurse capacity within the required timeframe (500 words max) - 30%** |
| *Please provide your response here:* |
| 1. **Describe your ability and past experience in engaging and retaining patients in a new program (500 words max) - 25%** |
| *Please provide your response here:* |
| 1. **Aboriginal cultural safety**   **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** | | | | |
| **No** | **Type of compliance document** | | **Document attached** | **Note**  *(if documents are not available, please provide reasons)* |
| **1** | **Provide copies of the relevant, current and valid accreditation certificates.** | | ☐ |  |
| **2** | **Provide the most recent audited financial statement** | | ☐ |  |
| **3** | **Provide required insurances attached including:** | |  |  |
|  | * Public liability insurance: Certificate of currency - $20 million per claim and in the aggregate of all claims | | ☐ |  |
|  | * Professional indemnity insurance: Certificate of currency - $10 million per claim and in the aggregate of all claims | | ☐ |  |
|  | * Workers compensation as required by the law | |  |  |
| **4** | Aboriginal and Torres Strait Islander Impact Statement, Aboriginal and Torres Strait Islander Health Strategy or a Reconciliation Action Plan. | |  |  |
| **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 up until 30 June 2027, commencing in the second half of 2024. |  |
| 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 invoices on a quarterly basis to COORDINARE – South Eastern NSW PHN on enrolled patients seen throughout that quarter.. |  |
| 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:** |  | | |

**Note**: Word document with e-signature is accepted.