**GRANT APPLICATION**

**Healthy Heart Healthy Mind**

**[NAME OF ORGANISATION/SERVICE]**

**[DATE]**

Table of contents

[1. Applicant information 2](#_Toc183110573)

[1. Evidence of compliance 4](#_Toc183110574)

[2. Declaration 6](#_Toc183110575)

1. Applicant information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **For organisation** | | | | | | | |
| Organisation name: |  | | | | | | |
| ABN: (Required) |  | | | GST registration date | |  | |
| Organisation address: |  | | | | | | |
| Town: |  | | | **Postcode:** | |  |
| rganisation phone: |  | | | | | | |
| Key contact person: | Name: | |  | | | | |
| Position in organisation: | |  | | | | |
| Email: | |  | | | | |
| Mobile phone: | |  | | | | |

1. Grant Assessment Criteria

Please provide responses to the criteria outlined below. Note that responses will be considered in the context of the size and resources of the organisation or applicant. Please indicate ‘N/A’ if any of the responses required are not relevant to your organisation or service.

|  |
| --- |
| 1. **Practice Information – 35% Word Limit 450 words**   Provide a brief overview of your General Practice including the following components:   * what are your General Practice’s special interests * have you held any nurse led clinics previously, and * how your team works together in a collaborative way. |
| *[please provide your answer here]* |
| 1. **Consumer focused design and delivery – 25% Word Limit 350 words**   Provide a brief overview of how you see this initiative working within your practice, including the following key components:   * Describe how you intend to embed the provided Practice Nurse into your practice.  Do you currently have a practice nurse? * Please indicate if you would like to host a mental health practitioner in phase 2 of the program and why you believe this would be valuable for your practice. |
| *[please provide your answer here]* |
| 1. **Working with vulnerable people – 20% Word Limit 350 words**  * Can you provide a summary of your practice caseload including any challenges you face providing care. * How you would use this program to improve patient outcomes for vulnerable communities in your region. * Outline your experience in working with Aboriginal and Torres Strait patients, what processes do you have in place to ensure they feel culturally safe? |
| *[please provide your answer here]* |
| 1. **Governance and Leadership – 10% Word Limit 350 words**  * What supports are in place that you can offer the Practice Nurse? * Please provide details of the GP team and availability. * Do you have access to MDT arrangements and allied health support * Do you provide aftercare hours support? |
| *[please provide your answer here]* |
| * **Funding Expenditure – 10% Word Limit 200 words**   The amount of funding available to each individual commissioned small practice is up to $15,000 (Ex GST). This funding is to cover the costs of preparing the practice for a part-time Practice Nurse.   * Please provide a summary of how your practice intends to use this funding in accordance with section 4. |
| *[please provide your answer here]* |

***Additional Questions:***

Would your practice be interested in the inclusion of mental health and wellbeing workforce? Yes / No

1. Evidence of compliance

Please attach the below documents together with your proposal via email to [commissioning@coordinare.org.au](mailto:commissioning@coordinare.org.au)

**Compliance Documents (Mandatory)**

|  |  |
| --- | --- |
| 1. **Provide copies of your current accreditation certificate(s) from your professional body (if applicable).** | **Compliance** |
| 1. **Provide copies of required insurances**  * Public liability insurance $20 million per claim and in the aggregate of all claims * Professional indemnity insurance $10 million per claim and in the aggregate of all claims | **Compliance** |

1. Declaration

|  |  |
| --- | --- |
| ***This must be completed by an authorized representative of the organisation submitting the application:*** | **Agree** |
| I declare that the organisation is able to implement the project within the proposed time frame. |  |
| 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 the organisation is financially viable and able to manage the funding within the proposed timeframe and within the proposed budget. |  |
| I understand and accept that information provided in this proposal may be stored by COORDINARE – South Eastern NSW PHN in various hardcopy and/or electronic formats. |  |
| I understand that this proposal 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 proposal 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. |  |

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