

Expression of Interest - Application Form

Collaborative Commissioning SENSW – Respiratory Scientist

Section A – Organisation Information

Applicant name:			
Organisation (if any)			
ABN (Applicant):		Is the applicant registered for GST?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
	Town:	Postcode:	
Phone number:			
Key contact person:	Name:		
	Title/Position in organisation (if any):		
	Email:		
	Mobile phone:		

Section B – Assessment Criteria

1. Outline your approach to delivering spirometry testing and required support to the commissioned General Practices, over a large region i.e SENSW PHN. (500 words max) - 35%

Please provide your response here:

2. Demonstrate your operational and technical capacity, capability and experience in successfully undertaking spirometry testing and result review. (500 words max) - 30%

Please provide your response here:

3. Describe your ability and past experience in supporting general practitioners with the management of difficult COPD patients through monthly review meetings. (500 words max) - 25%

Please provide your response here:

4. Budget clearly outlines the activities required to deliver the respiratory specialist's portion of the COPD Care Pathway - 10%

- *Travel and accommodation costs associated with visiting commissioned practices to carry out spirometry testing.*
- *The respiratory scientist's time to attend a monthly COPD patient review meeting with commissioned general practices.*
- *Mentor practice staff who will be tasked with undertaking spirometry testing moving forward.*

Please provide your response here:

Section C – Compliance

Provide copies of your accreditation certificates	Current accreditation attached	<input type="checkbox"/>
Provide the most recent financial audited acquittals (if applying as an organisation)	Financial audited acquittals attached	<input type="checkbox"/>
Provide required insurances attached including:		
<ul style="list-style-type: none"> Public liability insurance: Certificate of currency - \$20 million per claim and in the aggregate of all claims (if applicable). 	Public liability attached	<input type="checkbox"/>
<ul style="list-style-type: none"> Professional indemnity insurance: Certificate of currency - \$10 million per claim and in the aggregate of all claims 	Professional indemnity attached	<input type="checkbox"/>
<ul style="list-style-type: none"> Workers compensation as required by the law (if applicable). 	Workers' compensation policy attached	<input type="checkbox"/>

Referees

Include two (2) professional referees for new funding recipients.
Applicants 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:	

Section D– Declaration

<i>This must be completed by an authorised representative of the organisation submitting the application:</i>	Agree
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I declare that the organisation is able to implement the project within the designated time frame for a 12-month period commencing in the second half of 2024.	<input type="checkbox"/>
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.	<input type="checkbox"/>
I declare that funding has not been sought or received for this activity from any other source.	<input type="checkbox"/>
I declare that the organisation is financially viable and able to manage the funding within the timeframe and within budget.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
I understand that I am required to have current and adequate insurances in place.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>

Authorised Representative Name:		Date:	
Position of Authorised Representative:			
Authorised Representative Signature:			