Grant Application Form

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| Older adults primary care capacity building program |

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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:** | |  | | | |
| **Appointed practice nurse for this grant** | **Name:** | |  | | | |
| **Position in organisation:** | |  | | | |
| **Email:** | |  | | | |
| **Mobile phone:** | |  | | | |
| **AHPRA Registration number:** | |  | | | |

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| **Section B – Assessment Criteria** |
| 1. **Interest in Gerontological Nursing Competencies (GNC) Program and implementation plan (approximately 1000 words max) - 30%** |
| *Describe the reasons your practice nurse is interested in completing the Gerontological Nursing Competencies (GNC) program and detail your approach to planning and delivering the activity, including:*   * *Reason for Practice Nurse interest and benefits to practice capacity:*   + *explain how they meet the GNC course entry requirements criteria*   + *explain why your practice nurses is interested in the course and what they how to achieve by completing the course*   + *describe how their participation will enhance the practice's capacity* * *Review of practice data:*   + *Use practice data to support the need for the activity, examples include:*     - *Total number of individuals aged 65 plus*     - *Number of 45-49 year or 75-year health assessment*     - *Number with associated chronic conditions/risk factors*   + *Identify potential practice population that will benefit from the activity* * *Practice level review and workflow enhancements*   + *Detail how you will lead a review of current workflows at the practice level*   + *Outline potential strategies to enhance these workflows.*   *Key factors to consider include:*   * *specify strategies aimed at improving care for older adults* * *outline the expected benefits of these strategies* * *identify activities that could be undertaken by the practice team to improve patient outcomes, such as improved patient appointments, review of care planning, timely and appropriate referrals, investment in care coordination and outreach options.* |
| *Please provide your response here:* |
| 1. **Sustainability (approximately 500 words max) - 25%** |
| *Explain how your practice will continue to use the knowledge and experience gained by the practice nurse during the education program and embed the enhanced workflow activity resulting in sustained change over the long term, including the following key components:*     * *What strategies will be put in place to ensure the activity is embedded into practice workflow processes and procedures.* |
| *Please provide your response here:* |
| 1. **Quality improvement approach (approximately 500 words) - 10%** |
| *Please submit an example of a previous quality improvement project or activity that your practice has completed and shows how your practice:*     * *Identified the area for improvement, implemented the change and monitored progress.* |
| *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.** |
| *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:* |
| 1. **Roles and responsibilities (approximately 500 words) - 10%** |
| *Practices must commit minimum resources to this project of 1 Practice Nurse (who is enrolled in the GNC program) to lead the design and implementation of the project. Additionally, 1 General Practitioner and 1 administrative staff member to support the project. Outline the practice staff that will be involved in the project including:*   * *Details of which staff will be responsible for the activities outlined in the scope and specifications.* |
| *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 your current practice accreditation certificate(s) from your professional body | | ☐ |  |
| **2** | Aboriginal and Torres Strait Islander Impact Statement, Aboriginal and Torres Strait Islander Health Strategy or a Reconciliation Action Plan (optional) | |  |  |
|  | **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: |  | |  |
| **How did you hear about this opportunity?**  COORDINARE website ([Funding opportunities](https://www.coordinare.org.au/commissioning/funding-opportunities-list/better-pain-management-course-grant))  COORDINARE LinkedIn  Staying Ahead  In the loop  Direct email via Commissioning mailbox  Friends/Colleagues  Others (please specify) | | | | |

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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 2026. |  |
| If this application is successful, I agree to provide required deliverables to COORDINARE – South Eastern NSW PHN via designated platform (Folio Contract Management System). | **☐** |
| 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.   * Public liability insurance $10 million per claim and in the aggregate of all claims * Professional indemnity insurance $5 million per claim and in the aggregate of all claims * Copy of your workers compensation insurance policy for NSW. |  |
| 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. |  |
| By signing this declaration, the signatory below represents, warrants and agrees that they have been authorised by the Respondent to make this declaration on its/their behalf. |  |

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

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