Expression of Interest - Application Form

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| Collaborative Commissioning SENSW – Pulmonary Rehabilitation |

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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. Explain your experience in delivering rehabilitation services and your interest in this program.
	1. **Outline your experience in delivering rehabilitation services, include the nature of the injury / illness for which the services were delivered.**
	2. **Outline why you are applying to deliver this service, what is your interest in pulmonary rehabilitation.. (500 words max) - 35%**
 |
| *Please provide your response here:* |
| 1. **Demonstrate your willingness to under the necessary pulmonary rehabilitation training, if required. If not required, please explain why. (500 words max) - 15%**
 |
| *Please provide your response here:* |
| 1. **Describe your ability to meet the minimum requirement of holding two one hourly group pulmonary rehabilitation sessions each week. (500 words max) - 30%**
 |
| *Please provide your response here:* |
| 1. **Outline times when you have had to assist patients with the completion of a St George’s Respiratory Questionnaire for COPD patients (SGRQ-C) or similar, and how this was achieved - 10%**
 |
| *Please provide your response here:* |
| 1. **Aboriginal cultural safety - Provide a brief outline of what steps you are taking to ensure your service is safe and appropriate for Aboriginal and Torres Strait Islander people – 10%**
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| *Please provide your response here:* |

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| **Section C – Compliance** |
| **Provide copies of your current accreditation certificates.**  | Current accreditation attached | [ ]  |
| **Provide required insurances attached including:** |  |   |
| * Public liability insurance: Certificate of currency - $20 million per claim and in the aggregate of all claims
 | Public liability attached | [ ]  |
| * Professional indemnity insurance: Certificate of currency - $10 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 - $1 million per claim and in the aggregate of all claim (optional)
 | Cyber Security certificate attached | [ ]  |
| * Confirmation the General Practice has an Aboriginal and Torres Strait Islander Impact Statement or Health Strategy or Reconciliation Action Plan.
 |  | [ ]  |
| **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: |  |

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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 for a 12-month period 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 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:***[e-signature is accepted]* |  |