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%** |
| *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]* |  | | |