**GRANT APPLICATION**

**Enhancing health and wellbeing services for vulnerable populations**

**[NAME OF ORGANISATION/SERVICE]**

**[DATE]**

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1. Applicant information

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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. **Service model overview – 35%**   Provide a brief overview of your pre-existing service, including the following key components:   * Describe the health service or program delivered, including any contextual information about the broader organisation or service that it is part of * Outline the existing resources attached to the service or program e.g. staffing profile * Describe how you intend to enhance, expand or sustain the current service * Describe the geographical reach of the activity * Describe your existing relationships with other key services locally |
| *[please provide your answer here]* |
| 1. **Working with vulnerable communities – 25%**  * Outline your target population and your experience working with this particular vulnerable group/s * Outline the unmet needs of your identified community which your service addresses |
| *[please provide your answer here]* |
| 1. **Consumer-focused design and delivery – 20%**  * Describe how your current service supports the activation and empowerment of consumers to engage in improving their health and wellbeing * Outline the process in place to collect and implement consumer feedback |
| *[please provide your answer here]* |
| 1. **Governance and Leadership – 10%**  * Provide a brief overview of your organisation’s existing operational and clinical management functions and how they will relate to this project (if applicable) * Details of existing clinical governance arrangements including relevant policies and procedures (if applicable) |
| *[please provide your answer here]* |
| 1. **Budget explanation – 10%**  * The amount of funding available for individual grants is up to $80,000. * Please provide a detailed breakdown (**Attachment 2** – Budget template) of proposed expenditure. |
| *[please provide your answer here]* |

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)

|  |  |  |  |
| --- | --- | --- | --- |
| No | Compliance Document | Document attached | If document(s) is not available/applicable, provide a reason |
| 1 | Budget for FY24/25 and 25/26 on the budget template provided (**Attachment 2**). |  |  |
| 2 | Copies of your accreditation certificates (if applicable) |  |  |
| 3 | Insurances including: |  |  |
| * Public liability insurance: Certificate of currency - $20 million per claim and in the aggregate of all claims |  |  |
| * Professional indemnity insurance: Certificate of currency - $10 million per claim and in the aggregate of all claims. |  |  |
| * Workers compensation as required by the law. |  |  |
| * (Optional) Cyber security insurance: Certificate of currency - $1 million per claim and in the aggregate of all claims |  |  |
| 4 | (Optional) Aboriginal and Torres Strait Islander Impact Statement, Health Strategy or Reconciliation Action Plan. |  |  |
| 5 | Past 2 years audited financial statements or profit and loss statements. |  |  |
| 6. | Aboriginal and Torres Strait Islander Impact Statement, Aboriginal and Torres Strait Islander Health Strategy or a Reconciliation Action Plan (Optional) |  |  |

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| --- | --- |
| **Include at a minimum two (2) professional referees**  Organisations that have previously received funding from COORDINARE are not required to provide a referee. | |
| **Referee 1 Name:** |  |
| Position: |  |
| Organisation: |  |
| Email: |  |
| Phone: |  |
| **Referee 2 Name:** |  |
| Position: |  |
| Organisation: |  |
| Email: |  |
| Phone: |  |

1. 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 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 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. |  |

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