Expression of Interest - Application Form

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| **Connect Well Outreach Healthcare for Victim-Survivors of Family, Domestic & Sexual Violence: GP Clinics** |

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| **Section A – Organisation Information** |
| **Entity name:** |  |
| **Business Name:** |  |
| **ABN: (Required)** |  | **Is the Entity registered for GST?** |[ ]  **Yes** |
|  |  |  |[ ]  **No** |
| **Business address:** |  |
|  | **Town:** |  | **Postcode:** |  |
| **Business phone:** |  |
| **Key contact person #1:*****\*Person that will manage/coordinate the project***  | **Name:** |  |
|  | **Position in business:** |  |
|  | **Email:** |  |
|  | **Mobile phone:** |  |
| **Key contact person #2:****\**Person that is authorised to sign the contract*** | **Name:** |  |
|  | **Position in business:** |  |
|  | **Email:** |  |
|  | **Mobile phone:** |  |

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| **Section B – Assessment Criteria** |
| 1. **Practice Information - Word Limit 1000 - 35%**

 Provide a brief overview of your practice, including the following components: * in which of the three locations you are based
* details of the nominated GP’s interests and experience
* the capacity of your practice and the nominated GP to deliver the clinic detailed in this EOI document
 |
| *Please provide your response here:* |
| 1. **Consumer-focused design and delivery - Word Limit 1000 - 35%**

 For the nominated GP, provide a brief overview of their: * experience working in a multidisciplinary team (*including non-health workers*) providing services to vulnerable patients
* understanding of the complex needs of families who have experienced family, domestic and/or sexual violence and who are in crisis accommodation
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| *Please provide your response here:* |
| 1. **Working with vulnerable communities - Word Limit 1000 -30%**

 For the nominated GP, provide a brief overview of their: * willingness to undertake training in trauma informed care
* experience in working with individuals who are vulnerable, and an understanding of the complexities associated with providing comprehensive primary health care
* experience in working with Aboriginal and Torres Strait patients, and processes you follow to ensure they receive culturally safe health care
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| *Please provide your response here:* |

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| **Section C – Compliance** |
| **Provide copies of your current accreditation certificate(s) from your professional body (if applicable).** | Current accreditation attached | [ ]  |
| **Provide copies of required insurances:**  |  |   |
| * 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 | [ ]  |
| [ ] **eferees****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 deliver the GP clinic within the designated time frame from date of contract execution until June 2027. |[ ]
| 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]* |  |