Expression of Interest - Application Form

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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:** | |  | | | |

|  |
| --- |
| **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 |
| *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 |
| *Please provide your response here:* |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: |  | | |

|  |  |
| --- | --- |
| **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. |  |

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