Expression of interest - Application Form

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| Interprofessional Education and Collaborative Practice Program |

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| **Section A – Organisation Information** | | | | | | | | | | | | | | | |
| **Organisation name:** |  | | | | | | | | | | | | | | |
| **ABN: (Required)** |  | | | | **Is the organisation registered for GST?** | | | | | | | |  | | **Yes** |
|  | | **No** |
| **Organisation address:** |  | | | | | | | | | | | | | | |
| **Suburb:** | |  | | | | | **Postcode:** | | | | |  | | |
| **rganisation phone:** |  | | | | | | | | | | | | | | |
| **Key contact person:** | **Name:** | | | |  | | | | | | | | | | |
| **Position in organisation:** | | | |  | | | | | | | | | | |
| **Email:** | | | |  | | | | | | | | | | |
| **Mobile phone:** | | | |  | | | | | | | | | | |
| **Currently participating in the WIP – PS (as noted in eligibility criteria)** | | | | |  | | **Yes** | | |  | | **No** | | | |
| **Total health professionals engaged as part of the multidisciplinary team supported by the WIP – PS Incentive:** | | | | |  | | **Headcount** | | |  | | **FTE** | | | |
| **Types of health professionals engaged supported by the WIP – PS:** | | | | | General Practitioners | | | | | Nurse Practitioners | | | | | |
| Registered Nurses | | Enrolled Nurses | | | Midwives | | | | | Aboriginal and Torres Strait Islander Health Workers | | | | | |
| Aboriginal and Torres Strait Islander Health Practitioners | | Physiotherapist | | | Psychologist | | | | | Podiatrist | | | | | |
| Dietician/Nutritionist | | Other Allied Professional  If other please list: | | | | | | | | | | | | | |
| **Total combined average hours per week for health professionals supported through the WIP – PS to deliver the following services:** | | | | **Clinical** | |  | **Telehealth** | |  | | **Outreach** | | |  | |
| **Other** | |  | | | | | | | | | |

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| **Section B – Scope and specifications** |
| 1. **Multidisciplinary models of care (suggested word count max 500 words) – 25%** |
| Please provide details of the multidisciplinary models of care supported by the WIP-PS within your practice that address community need. Include key factors that:   * Enable or inhibit these models * The range of activities undertaken by the multidisciplinary team to improve patient outcomes E.g. Patient appointments, referrals, practice administration, case coordination. |
| *Please provide your response here:* |
| 1. **Interprofessional education** **approach (suggested max word count max 500 words)- 25%** |
| Please provide details of your practices interprofessional education including:   * Describe any interprofessional education your practice currently does e.g. clinical in-services, case management reviews, clinic audits * Outline what enhancements or additions to your current education program you could implement to enhance your interprofessional education and capacity building. * You may want to consider submitting an example of a plan if you have one |
| *Please provide your response here:* |
| 1. **Sustainability (suggested word count max 500 words) - 25%** |
| Explain how your practice will identify and embed interprofessional educational activities resulting in collaborative practice over the long term, including the following key components:     * What systems, policies and / or procedures do your practice have in place that:   + supports continual learning and development as part of the organisational culture.   + Identify learning opportunities, facilitate learning and evaluate progress. * What strategies will be put in place to ensure the IPE activities are purposeful, meaningful to the clinical setting and the delivery of quality patient care. |
| *Please provide your response here:* |

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| 1. **Roles and responsibilities (suggested word count max 500 words) – 25%** | | |
| Practices must commit minimum resources to lead and implement this project of 1 General Practitioner, 1 Practice Nurse and / or WIP – PS eligible health professional and 1 administrative staff member.   Outline the practice staff that will be involved in the project including:   * Details of which staff will be responsible for the activities outlined in the scope and specifications and championing IPE within the practice. | | |
| *Please provide your response here:* | | |
| **Section C – Compliance** | | |
| **Provide copies of your accreditation certificates.** | Current accreditation attached |  |

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| **How did you hear about this opportunity?**  COORDINARE website ([Funding opportunities](https://www.coordinare.org.au/commissioning/funding-opportunities-list/better-pain-management-course-grant))  COORDINARE LinkedIn  COORDINARE Health Coordination Consultant  Staying Ahead  In the loop  Direct email via Commissioning mailbox  Friends/Colleagues  Facebook  Others (please specify) |

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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 (approximately 07 months until 30 November 2025) |  |
| 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, including   * Public liability insurance: Certificate of currency - $10 million per claim and in the aggregate of all claims. * Professional indemnity insurance: Certificate of currency - $5 million per claim and in the aggregate of all claims. * Workers compensation as required by the law. |  |
| 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:** |  | | |

Note: *E-signature is accepted. Submission in Word format is accepted.*