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%**
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| 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.
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| *Please provide your response here:* |
| 1. **Interprofessional education** **approach (suggested max word count max 500 words)- 25%**
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| 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%**
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| 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.
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| *Please provide your response here:* |

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| 1. **Roles and responsibilities (suggested word count max 500 words) – 25%**
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| 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.
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| *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.*