**RFP-2526-01**

Alcohol and Other Drugs - Innovation Grants

**GRANT APPLICATION**

**[NAME OF ORGANISATION/SERVICE]**

**[DATE]**

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1. Applicant information

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| --- |
| Section A – Organization 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 authorized to sign the contract* | **Name:** |  |
| **Position in business:** |  |
| **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. **Innovation Initiative Overview - 45%**

Provide a brief overview of the proposed initiative, including the following key components:* priority population/s you will support and how your proposed initiative will address the unmet needs of your identified group/s
* project team that will support the initiative
* engagement with key stakeholders and services
* geographical reach of the proposed activity
* timelines to implement the activity
 |
| *[please provide your answer here]* **(1,000 max word limit)** |
| 1. **Engagement and participation of priority communities -** **25%**
* outline your organisation and experience working with the identified group/s
* outline any co-design you have undertaken or will do (if applicable) to support the proposed initiative
* describe how the initiative will support and empower consumers to engage in improving their health and wellbeing
* describe the outcomes sought, how these would be measured and with whom these will be achieved (consumer/carer/systems level)
 |
| [please provide your answer here] **(1000 max word limit)** |
| 1. **Evaluation and sustainability – 20%**

Describe how your proposed model will benefit your identified group/s including:* how you will evaluate the impact of the initiative
* processes to collect consumer feedback
* sustainability of the project beyond the funding period
* potential for broader long-term impact, for example, scalability
 |
| *[please provide your answer here]* **(500 max word limit)** |
| 1. **Budget and risk management– 10%**

The amount of funding available for individual grants is $50,000 up to $150,000 (excl. GST)* provide a detailed breakdown (**Attachment 2** – Budget template) of the proposed expenditure for 24/25FY
* provide a risk assessment on the initiative with details on how your organisation will mitigate any identified risk.
 |
|  *[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

|  |  |  |  |
| --- | --- | --- | --- |
| No | Compliance Document | Document attached | If document(s) is not available/applicable, provide a reason |
| 1 | Budget for FY25/26 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)  | [ ]  |  |

|  |
| --- |
| **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. |[ ]

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