Expression of Interest - Application Form

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| Collaborative Commissioning SENSW – Pulmonary Rehabilitation(Open Round) |

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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. Explain your experience in delivering rehabilitation services and your interest in this program – 35% (1500 words max)
* Outline your experience in delivering rehabilitation services, include the nature of the injury / illness for which the services were delivered.
* Outline why you are applying to deliver this service, what is your interest in pulmonary rehabilitation.
 |
| *Please provide your response here:* |
| 1. **Describe your ability to meet the minimum requirement of holding two one hourly group pulmonary rehabilitation sessions each week. (1000 words max) - 30%**
 |
| *Please provide your response here:* |
| 1. **Demonstrate your willingness to under the necessary pulmonary rehabilitation training, if required. If not required, please explain why (500 words max) - 15%**
 |
| *Please provide your response here:* |
| 1. **Outline times when you have had to assist patients with the completion of a Health-Related Quality of Life survey or similar survey tools, and how this was achieved (500 words max) - 10%**
 |
| *Please provide your response here:* |
| 1. **Aboriginal cultural safety (500 words max)** – 10%

Provide a brief outline of what steps you are taking to ensure your service is safe and appropriate for Aboriginal and Torres Strait Islander people.  |
| *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 | [ ]  |
| * Cyber Security - $1 million per claim and in the aggregate of all claim (optional)
 | Cyber Security certificate attached | [ ]  |
| * Confirmation the Provider has an Aboriginal and Torres Strait Islander Impact Statement or Health Strategy or Reconciliation Action Plan (Optional)
 | Document attached | [ ]  |
| * Provide the latest audited financial statements or profit and loss statements.
 | Documents attached | [ ]  |
| **Referees****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 implement the project 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]* |  |