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| 2023 ALLIED HEALTH CROSS BOUNDARY GRANT STREAM |
| **Application Form** |

Please complete this form and submit via [MyHETIconnect](https://www.heti.nsw.gov.au/cb-application) by **4 August 2023** to be considered. Sections A, B and C will be entered into the online form. This complete application form, the endorsement from the Allied Health director and the quote will need to be uploaded into MyHETIconnect.

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| Section A - GROUP DETAILS | | |
| **Name/description of allied health team/group:** | |  |
| **Please list the Local Health Districts / Specialty Health Networks included in this application:** | |  |
| **If a minimum of 50% of the group is located in a Rural or Remote Setting, please indicate the percentage and the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA):** <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/ra-intro> | |  |
| KEY CONTACT PERSON | | |
| **Name:** |  | |
| **Work Telephone:** |  | |
| **Work Email Address:** |  | |

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| Section B – CROSS BOUNDARY (CB) ACTIVITY DETAILS | | | | | | | |
| **Name of Cross Boundary activity:** | | | |  | | | |
| **Cross Boundary activity amount requested**   * **inclusive of GST- $** | | | |  | | | |
| **Location where the activity will take place:** | | | |  | | | |
| **Number of people involved in Cross Boundary activity:**   * Minimum 3 people | | | |  | | | |
| **Does your team include any members that identify as either Aboriginal or Torres Strait Islander?** | | | | No  Yes 🡺 (if so how many?)\_\_\_\_\_\_\_\_ | | | |
| **Disciplines of people involved in Cross Boundary activity:** | Allied Health Assistant | | Art Therapy | | | Audiology | |
| Aboriginal Health Worker/ Practitioner in AH support role | | Counselling | | | Dietetics & Nutrition | |
| Diversional Therapy | | Exercise Physiology | | | Genetic Counselling | |
| Music Therapy | | Nuclear Medical Tech. | | | Occupational Therapy | |
| Orthoptics | | Orthotics & Prosthetics | | | Pharmacy | |
| Physiotherapy | | Play Therapy | | | Podiatry | |
| Psychology | | Radiation Therapy | | | Radiography | |
| Sexual Assault | | Social Work | | | Speech Pathology | |
| Welfare | |  | | |  | |
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| **Are all members of this team employees of NSW Health?** | Yes | | | No\* 🡺 % NSW Health Employees | | | |
| *\*If ‘No’, please explain the established working relationship between NSW Health and non NSW Health team/group including its influence on patient care / workplace practices.* | | | | | | |
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| **Approx. % who are either allied health professionals or allied health assistants:**   * Minimum 75% | | | | % | | | |
| **If Cross Boundary activity involves an external presenter/ facilitator, have you attached a quote to this application?** | | | | Yes | No – this application will be ineligible if the presenter is not aware of this application | | Not applicable |
| **If required, could this activity be conducted virtually and/or in a Covid safe way if required?** | | | | Yes | No | | |
| Please describe: | | | |
| **Will the Cross Boundary activity be completed by 30/06/2024?** | | | | Yes | No | | |
| Section C – KEY CONTACT PERSON COST CENTRE MANAGER CONTACT DETAILS | | | | | | | | |
| **Name of Key Contact Person cost centre manager:** | |  | | | | | | |
| **Email address:** | |  | | | | | | |
| **Telephone number:** | |  | | | | | | |
| **Cost centre number** | |  | | | | | | |

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| DIRECTOR OF ALLIED HEALTH ENDORSEMENT (from your district or network) | |
| **Name:** |  |
| **Designation:** |  |
| **Email Address:** |  |
| **Phone number:** |  |

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| KEY CONTACT PERSON DECLARATION | | |
| I, as the Key Contact Person, declare that the information we have provided in this application is, to the best of my knowledge, true and accurate. In signing this application on behalf of the group, I confirm that we:   1. have sought approval for conducting this Cross Boundary learning activity from the line managers of all people included in this application 2. have support from my Director of Allied Health 3. have read the *2023 Allied Health Cross Boundary Grant Program* *Terms & Conditions* 4. agree to fulfil the requirements set out in the *2023 Allied Health Cross Boundary Grant Program* *Terms & Conditions* 5. will reimburse the funding back to HETI if we are granted funding and the proposed Cross Boundary learning activity does not take place 6. are not aware of any related interest, pecuniary or non-pecuniary, that may create, appear to create or have potential to create, a conflict of interest 7. will immediately bring to the attention of the HETI allied health team any change in circumstances 8. will complete an evaluation of this activity on survey monkey before 31 July 2024 9. will nominate another Key Contact Person if I am no longer available to continue this responsibility e.g. no longer employed in NSW Health or change to new unrelated role | | |
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| **Name** |  | **Date** |

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| Section D – CROSS BOUNDARY (CB) ACTIVITY DETAILS | | | |
| 1. **Name of the proposed Cross Boundary activity:** | | | |
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| 1. **Please provide a detailed description of the proposed Cross Boundary activities** (including; detailed plan and purpose of the activity. Clear information on name of education provider, audience, location, timeframes. Include a training outline where possible) *approx. 300 words* | | | |
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| 1. **Outline of existing working relationship between the group members.** Include frequency or working together and reason for connection | | | |
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| 1. **Please provide justification based on evidence of why this Cross Boundary activity is important for your group and how it will improve clinical / workplace practices or patient care outcomes** (including reference to evidenced based practice, literature, data and/or links to NSW Health documents).   **Consider how the training** **would change current practice**. *approx. 500 words* | | | |
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| 1. **Please state three learning objectives for the proposed Cross Boundary activity.** *Learning objectives should be specific and measurable and where appropriate, linked to the evaluation* | | | |
| **i.** |  | | |
| **ii.** |  | | |
| **iii.** |  | | |
| 1. **What does this training mean for Aboriginal and Torres Strait Islander people?** (Please consider cultural and social impact). For example, will training in this area have a positive impact on service delivery for Aboriginal and Torres Strait Islander people? <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_034.pdf>. | | | |
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| 1. **Please provide an overview of how you would evaluate this Cross Boundary activity** (including; purpose, evaluation focus questions, data sources, methods and dissemination. Medium and Long term evaluation plans, example evaluation survey or focus questions and/or sustainability considerations will support strength of applications compared to immediate plans only) *approx. 300 words* | | | |
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| 1. **Please describe why this training is value for money or cost effective** | | | |
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| 1. **Please provide a budget of how the grant funds would be spent** (including; specific information, quotation is compulsory) | | | |
| **ITEM** | | | **ESTIMATED COST** |
|  | | | $ |
|  | | | $ |
|  | | | $ |
|  | | | $ |
| **TOTAL COST – inclusive of GST** | | | **$** |
| If total cost exceeds $4,000 (or up to $4,500 if rural),  please indicate how additional  funds will be accessed | |  | |