## **Request for Proposal (RFP) Response Form**

## **Healthy Ageing Early Intervention (PAC095)**

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| **Organisation Information** | |
| **Legal Entity Name** |  |
| **Trading/Business Name** *(if applicable)* |  |
| **Australian Business Number** *(ABN)* |  |
| **Entity Type** | Choose an item. |
| **Business Address** *(physical)* |  |
| **Business Address** *(mailing)* |  |
| **Telephone** |  |
| **Email** |  |
| **Contact details for RFP** | |
| **Name** |  |
| **Position** |  |
| **Phone** |  |
| **Email** |  |

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| **Assessment Criteria** | **Weighting** |
| 1. **1. Relevant Experience and Capabilities** |  |
| * 1. Describe the activity/activities you intend to conduct under the Healthy Ageing, Early Intervention Program. Please include information on:  1. description of the proposed activity/activities with defined scope and eligibility criteria for participants; 2. detail the number of participants/sessions/resources to be supported/developed in this program; 3. the evidence to support the effectiveness of the proposed activity/activities; 4. the long-term change that the activity/activities aim to create/ the aim of the proposed activity/activities (e.g. changes in behaviours, knowledge, awareness, attitudes, beliefs, perceptions, skills); 5. outcomes of the proposed activity/activities. These outcomes should be measurable.   **Word limit – 500 words** | **15%** |
| *Response:* |  |
| **1.2** Tell us more about the local needs for your proposed activity/activities that relate to the aims of this funding:   1. the size of ACT population with identified needs in the ACT, demographics, relevant specific conditions and acuity level; 2. other needs/ gaps that the proposed activity/activities are going to address (refer to relevant sections of the [Capital Health Network 2021-2024 Needs Assessment;](https://www.chnact.org.au/wp-content/uploads/2022/03/Capital-Health-Network-ACT-PHN-2021-24-Needs-Assessment.pdf) 3. how the proposed activity/activities add value to the current services in the ACT.  The proposed activity/activities should NOT duplicate any existing services that are operating in the ACT.  If you are a current provider under this program, please include detail of the benefit of the extended activity.   **Word limit – 250 words** | **20%** |
| *Response:* |  |
| **1.3** Please discuss measures for tracking progress, success and evaluation here:   1. What [ICHOM patient outcome measures](https://connect.ichom.org/patient-centered-outcome-measures/older-person/) are being utilised for the proposed activity/activities? (further [ICHOM Measures information](https://chnact.sharepoint.com/:w:/g/hsi/integration/Eac8R_gIuLFJkaaoQiroKfEBiNapYeiGmCdgSLik1W35DQ?e=d3wk6v)) 2. What other measures will be used to monitor outcomes of the proposed activity/activities? 3. How will you collect the data for these outcome measures? And how often they will be collected?   **Word limit – 250 words** | **5%** |
| *Response:* |  |
| **1.4** Please discuss further implementation aspects of the proposed activity/activities here:   1. What is the strategy to recruit participants for the proposed activity/activities? 2. What is the strategy to retain engagement for the proposed activity/activities? 3. Who are the key partners your organisation will collaborate with? What is your current relationship with them? In what capacity will you collaborate?   **Word limit – 500 words** | **10%** |
| *Response:* |  |
| **1.5** Tell us about your organisation’s capacity to deliver the proposed activity/activities, including:   1. Resources and infrastructure 2. Telehealth (if applicable) 3. Staffing, skills and experience. How can your organisation deliver this service successfully? 4. Longer term sustainability of the impact and/or program beyond the funding period   **Word limit – 250 words** | **20%** |
| *Response:* |  |
| **1.6.** Please indicate your proposed budget. Please note that:   1. Itemised budget is cost effective, within funding available and provides Value for Money. 2. Administration and service delivery costs should be specifically defined and itemised where practical. 3. Administrative costs are capped at a maximum of 14.5% of proposed budget. 4. All amounts included in the proposed budget must be GST-exclusive. | **10%** |
| *Response:* |  |
| 1. **2. Assurances and Compliance** | |
| **2.1 Conflict of Interest**  Provide details of any interests, relationships or clients which may or do give rise to a conflict of interest and the area of expertise in which that conflict or potential conflict does or may arise, plus details of any strategies for preventing and/or managing conflicts of interest (actual or perceived).  **Word limit 250 words** | **N/A** |
| *Response:* |  |
| **2.2   Risk management and mitigation strategies:**  Provide details of all risk management strategies and practices of the Applicant that would be applicable or relevant in the context of the supply of goods and/or services. Consider the following:   1. What are the potential barriers for older people to access your activity/activities? 2. What are the proposed mitigation strategies for the identified barrier(s)? 3. Are there any potential risks for older people when participating in your activity/activities? If yes, what are they? 4. How can you mitigate/control the identified risks? 5. What are the factors that may impact the success of the activity/activities? 6. How do you plan to mitigate the identified factors?   **Word limit 500 words** | **20%** |
| *Response:* |  |

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| **2.3** **Insurance information:** Provide details of all relevant insurances maintained by the Applicant. | | | | | |
| **Public Liability** | | | | | |
| **Insurance company** |  | | **Policy number** | |  |
| **Amount $** |  | | **Expiry date** | |  |
| **List any relevant exclusions:** | | | | | |
| **Professional Indemnity** | | | | | |
| **Insurance company** |  | | **Policy number** | |  |
| **Amount $** |  | | **Expiry date** | |  |
| **List any relevant exclusions:** | | | | | |
| **Work Cover (if applicable)** | | | | | |
| **Insurance company** |  | | **Policy number** | |  |
| **Amount $** |  | | **Expiry date** | |  |
| **List any relevant exclusions:** | | | | | |
| **2.4 Accreditation/Registration/Certification**:Provide relevant details as appropriate. | | | | | |
| **Accreditation/Registration/Certification** | | |  | | |
| **Accreditation/Registration/Certification** | | |  | | |
| **Standard/Obligation** | | |  | | |
| **2.5 Referees** | | | | | |
|  | | **Referee 1** | | **Referee 2** | |
| **Name** | |  | |  | |
| **Position** | |  | |  | |
| **Organisation** | |  | |  | |
| **Phone** | |  | |  | |
| **Email** | |  | |  | |
| **Relationship/details** | |  | |  | |

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| **DECLARATION** |

**Please read and sign the following declaration:**

* I have read and accept the Conditions outlined in Parts A, B & C in the RFP.
* I declare that the organisation is financially viable and able to provide the Service.
* I declare that all information provided in this application is true and correct.
* I understand and accept that information provided in this application will be stored by CHN in various formats including hard copy and/or electronic storage.
* I accept that the ‘*Standard Terms and Conditions (PHN)’* will form the basis of the Service Order and are not negotiable.
* I declare that as an applicant, this business is compliant with the Workplace Gender Equality Act 2012 (Cth).

I have supplied all the following Application requirements and supporting documentation (where required):

Completed Response form

Evidence of current Public Liability Insurance (eg. Certificate of Currency)

Evidence of current Professional Indemnity Insurance (eg. Certificate of Currency)

Evidence of Workers Compensation Insurance (eg. Certificate of Currency)

**Signed by authorised organisation representative:**

|  |  |
| --- | --- |
| **Signature** |  |
| **Date** |  |
| **Name** |  |
| **Position** |  |