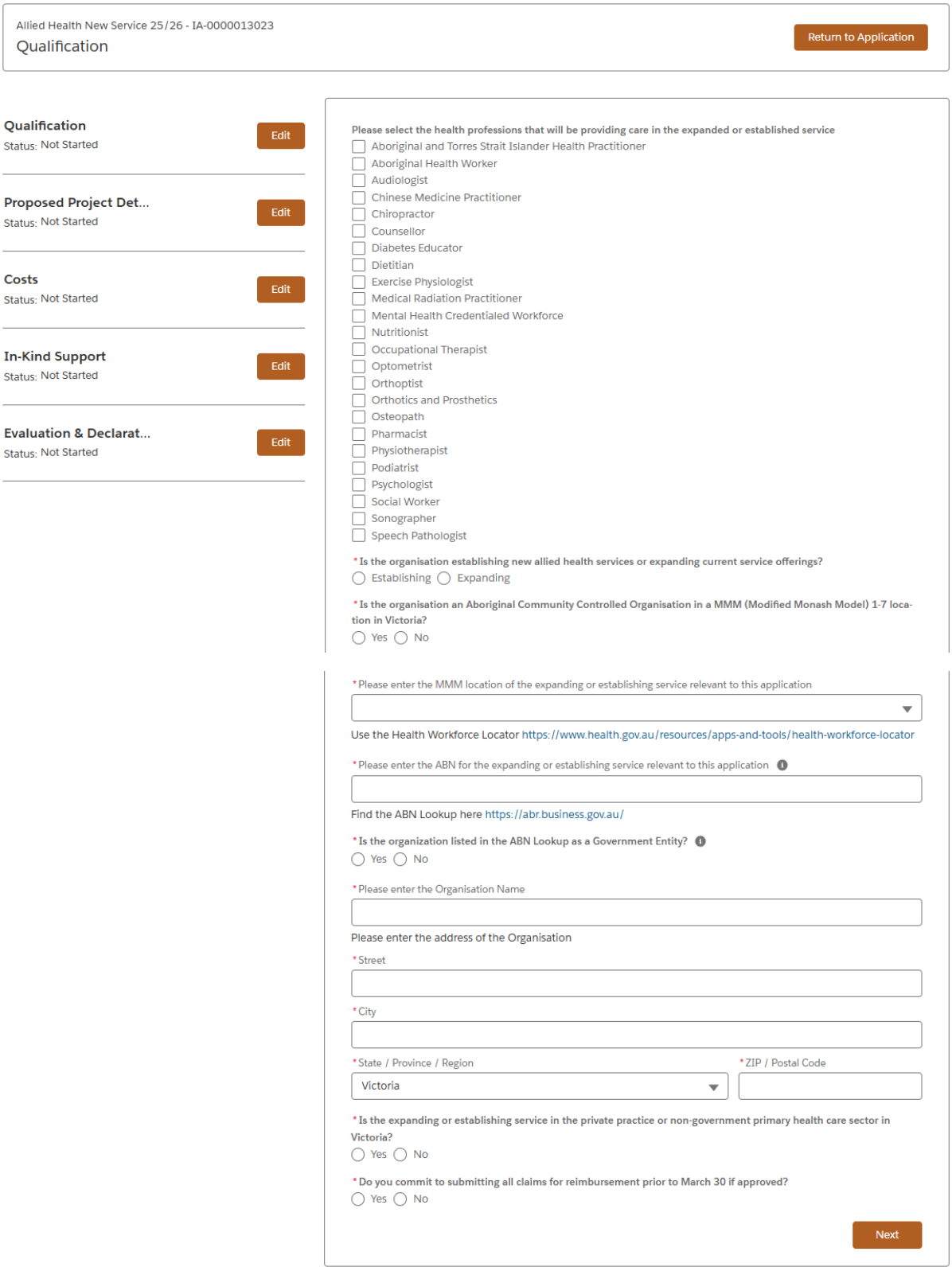
Allied Health New Service Grants 25/26 – Application Format



Allied Health New Service 25/26 - IA-0000013023

Qualification

Return to Application

Qualification
Status: Not Started
Edit

Proposed Project Det...
Status: Not Started
Edit

Costs
Status: Not Started
Edit

In-Kind Support
Status: Not Started
Edit

Evaluation & Declarat...
Status: Not Started
Edit

Please select the health professions that will be providing care in the expanded or established service

- [ ] Aboriginal and Torres Strait Islander Health Practitioner
- [ ] Aboriginal Health Worker
- [ ] Audiologist
- [ ] Chinese Medicine Practitioner
- [ ] Chiropractor
- [ ] Counsellor
- [ ] Diabetes Educator
- [ ] Dietitian
- [ ] Exercise Physiologist
- [ ] Medical Radiation Practitioner
- [ ] Mental Health Credentialed Workforce
- [ ] Nutritionist
- [ ] Occupational Therapist
- [ ] Optometrist
- [ ] Orthoptist
- [ ] Orthotics and Prosthetics
- [ ] Osteopath
- [ ] Pharmacist
- [ ] Physiotherapist
- [ ] Podiatrist
- [ ] Psychologist
- [ ] Social Worker
- [ ] Sonographer
- [ ] Speech Pathologist

* **Is the organisation establishing new allied health services or expanding current service offerings?**
◯ Establishing ◯ Expanding

* **Is the organisation an Aboriginal Community Controlled Organisation in a MMM (Modified Monash Model) 1-7 location in Victoria?**
◯ Yes ◯ No

* Please enter the MMM location of the expanding or establishing service relevant to this application

Use the Health Workforce Locator https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator

* Please enter the ABN for the expanding or establishing service relevant to this application

Find the ABN Lookup here https://abr.business.gov.au/

* **Is the organization listed in the ABN Lookup as a Government Entity?**
◯ Yes ◯ No

* Please enter the Organisation Name

Please enter the address of the Organisation

* Street

* City

* State / Province / Region
Victoria

* ZIP / Postal Code

* **Is the expanding or establishing service in the private practice or non-government primary health care sector in Victoria?**
◯ Yes ◯ No

* **Do you commit to submitting all claims for reimbursement prior to March 30 if approved?**
◯ Yes ◯ No

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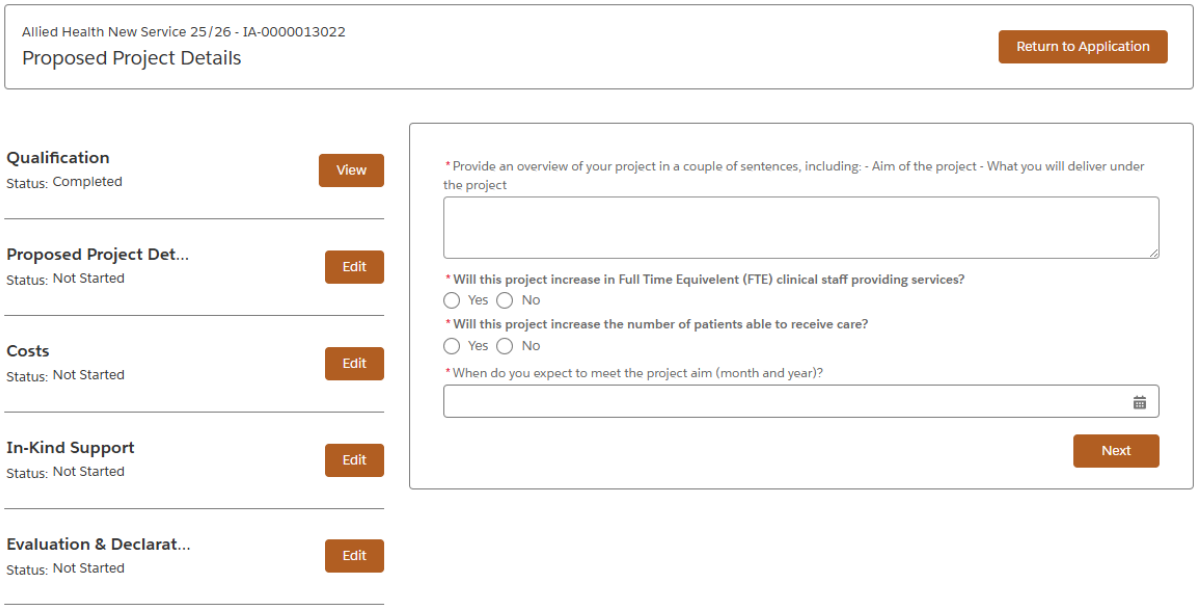
Allied Health New Service 25/26 - IA-0000013022
Proposed Project Details
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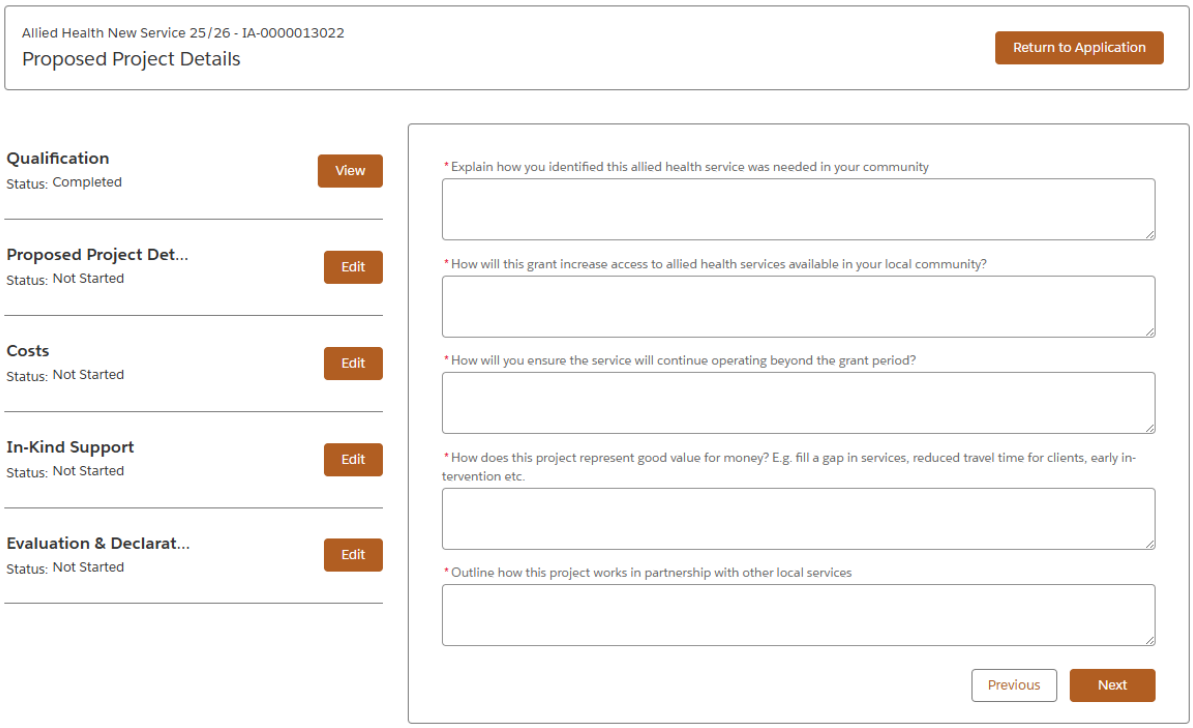
* Provide an overview of your project in a couple of sentences, including: - Aim of the project - What you will deliver under the project
* Will this project increase in Full Time Equivelent (FTE) clinical staff providing services?
Yes No
* Will this project increase the number of patients able to receive care?
Yes No
* When do you expect to meet the project aim (month and year)?
Next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* Explain how you identified this allied health service was needed in your community
* How will this grant increase access to allied health services available in your local community?
* How will you ensure the service will continue operating beyond the grant period?
* How does this project represent good value for money? E.g. fill a gap in services, reduced travel time for clients, early intervention etc.
* Outline how this project works in partnership with other local services
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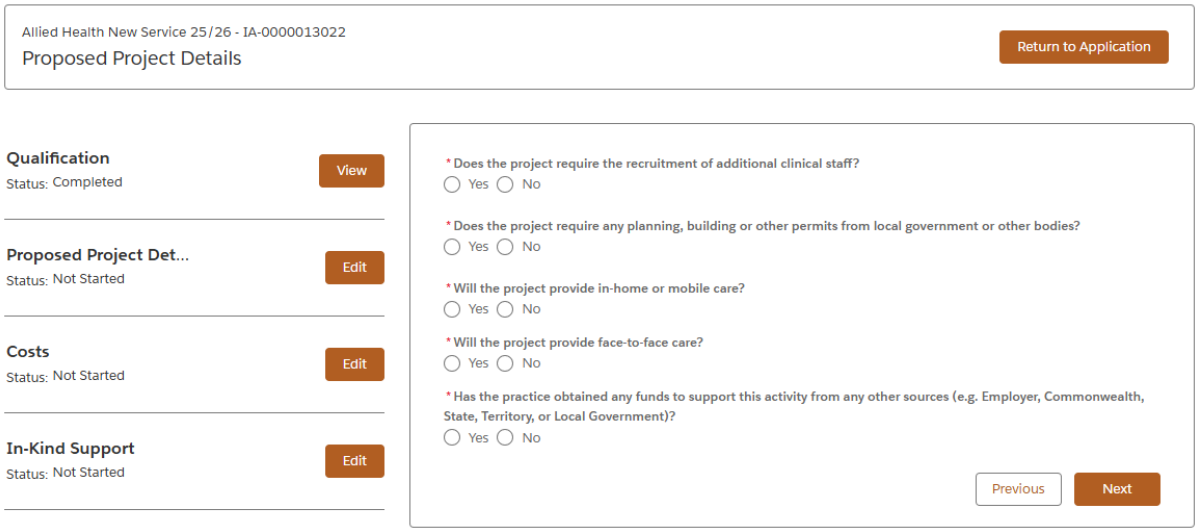
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* Does the project require the recruitment of additional clinical staff?
Yes No
* Does the project require any planning, building or other permits from local government or other bodies?
Yes No
* Will the project provide in-home or mobile care?
Yes No
* Will the project provide face-to-face care?
Yes No
* Has the practice obtained any funds to support this activity from any other sources (e.g. Employer, Commonwealth, State, Territory, or Local Government)?
Yes No
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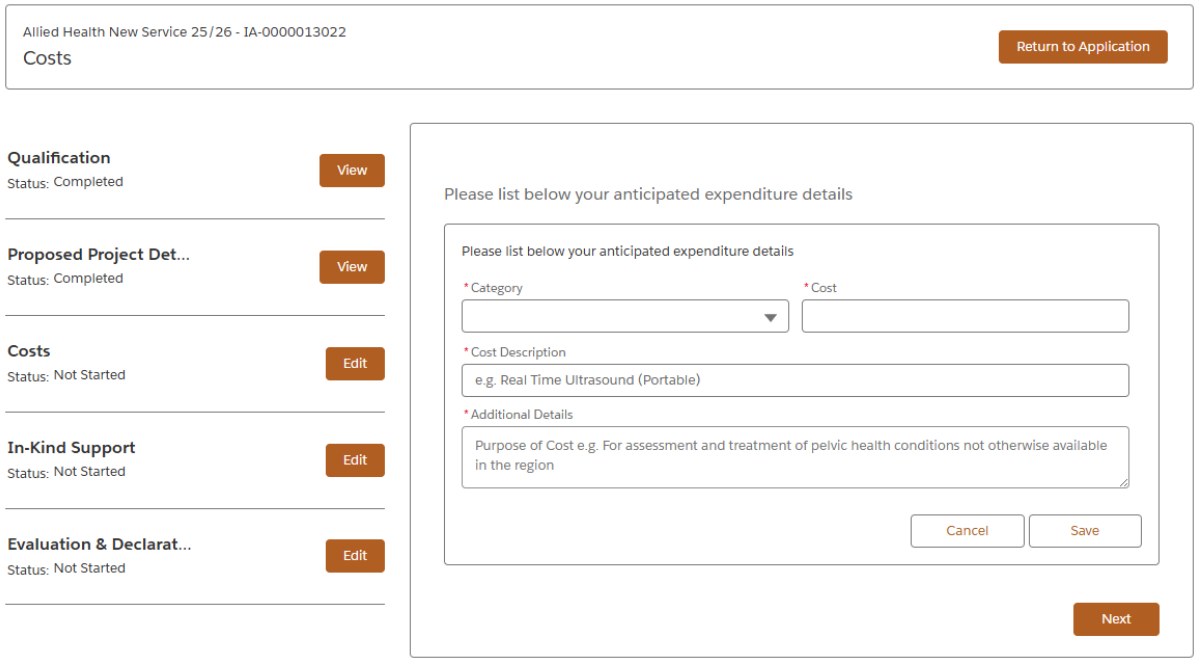
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Edit
Please list below your anticipated expenditure details
Please list below your anticipated expenditure details
* Category
* Cost
* Cost Description
e.g. Real Time Ultrasound (Portable)
* Additional Details
Purpose of Cost e.g. For assessment and treatment of pelvic health conditions not otherwise available in the region
Cancel
Save
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In-Kind Support

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In-kind support can be anything that will contribute to the establishment or expansion of the service that you do not seek to claim under the grant. In-kind support is required to be considered for this grant.

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* In-kind support details

e.g. Marketing of the Service, Equipment Purchased Out of Pocket or Clinic Rental/Modifications

Error: In-kind support details is required.

* Total Value

$

Cancel | Save

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Evaluation & Declaration

Return to Application

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* What was the PRIMARY way you found out about this grant?

* How long (in years) do you believe you will work in rural Victoria?

☐ I agree to future contact from the Rural Workforce Agency Victoria in relation to the evaluation of program outcomes

☐ I would like to receive the RWAV newsletter, as well as healthcare news about upcoming initiatives and programs in rural Victoria

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