**Innovation Fellowship 2024**

# **Application Form**

##### Due by: 1:00 pm (AWST) Monday 22 April 2024

* ***Please refer to the relevant*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities) ***which include application instructions.***
* ***Applicants are responsible for complying with internal deadlines and ensuring all certifications are complete prior to submission.***

## Activity title

|  |
| --- |
|  |

## Activity summary

Provide a **plain language** summary of the proposal, including the aims, objectives, significance and expected benefits to the health and/or wellbeing of the WA community. This summary may be used for publicity purposes.

*[Maximum 250 words]*

|  |
| --- |
|  |

## Innovation Maturity Level (IML)

|  |  |
| --- | --- |
| Select the IML of the proposed innovation Activity  *Must be within the range of IML 3 to IML 6 (see Guidelines and Conditions Appendix 1)* | IML 3 – Proof of Concept  IML 4 – Proof of Feasibility  IML 5 – Proof of Value  IML 6 – Preliminary Validation |

1. **Fellowship FTE and duration**

The total time dedicated to the Fellowship Activity must be 6 months, which may be completed full-time and/or part-time, within a maximum period of 12 months.

As such, the Activity may be undertaken as follows:

* full-time for 6 months; or
* part-time or a combination of full-time and part-time, within a maximum period of 12 months.

Indicate in the table below details of each full-time equivalent (FTE) and duration combination(s) that result in a total time allocation of 6 months of Fellowship Activity.

*Examples:*

* *1.0 FTE x 6 months, total time 6 months*
* *0.5 FTE x 12 months, total time 6 months*
* *1.0 FTE x 3 months plus 0.5 FTE x 6 months, total time 6 months*
* *0.75 FTE x 8 months, total time 6 months.*

|  |  |  |  |
| --- | --- | --- | --- |
| Plan to complete the 6-month total dedicated time for Fellowship Activity  *Describe the applicable FTE(s), and duration(s) that would result in the total time dedicated to the Fellowship Activity being 6 months* | FTE | Duration  (Number of months) | Total time |
|  |  |  |

## Funding request

The information provided below must align with the ‘Budget details’ table.

|  |  |
| --- | --- |
| Amount requested (ex GST)  *Up to $100,000 for Fellowship salary*  *Up to $50,000 for innovation Activity costs* | Fellowship salary $  Activity costs $ |
| Total Fellowship funding request  *Maximum $150,000 for the duration of the Fellowship* | $ |

## Activity classification

|  |  |
| --- | --- |
| **Burden of Disease** (up to 2) state the disease groups and names that are most applicable to your proposed Activity or have the highest burden  *Downloadable Australian Institute of Health and Welfare* [*Australian Burden of Disease Study*](https://www.aihw.gov.au/reports/burden-of-disease/abds-methods-supplementary-material-2018/data) *Table 2.1* | *e.g. Blood and metabolic disorders - Cystic fibrosis* |
| **Keywords** (up to 5)  *Must be selected from NHMRC*  [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Researcher > My Applications > Keyword Library*  *Note: Although this is an innovation Activity this source of keywords is used for consistency across grant reporting* | 1.  2.  3.  4.  5. |

## Responsible Entity

|  |  |
| --- | --- |
| Name of Responsible Entity  *Entity which would administer grant funds* |  |
| ABN |  |
| Registered address  *Must have a physical and operational presence in WA* |  |
| Contact officer pre-award  *(different to Activity Lead unless not possible e.g. Sole Trader)* | Name:  Position:  Email: |
| Contact officer post-award  *(different to Activity Lead unless not possible e.g. Sole Trader)* | Same as pre-award above  **or**  Name:  Position:  Email: |

## Activity Lead (Innovation Fellow)

Insert an abridged (two-page maximum) Curriculum Vitae (CV) which includes key innovation achievements over the last 5 years. CVs can be inserted at the end of this application form.

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| ORCiD (if relevant)  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  |
| Citizenship/residency status | Australian citizen  Australia permanent resident  New Zealand citizen  appropriate work visa |
| Within which area are you located | Perth metropolitan  Regional and remote |
| Grant arrangement  *Refer to ‘Eligibility’ section of the Guidelines and Conditions* | (a) employee of the Responsible Entity  or  (b) honorary or adjunct title at the Responsible Entity |
| If response to grant arrangement is (a), indicate further details | Position at Responsible Entity: |
| If response above is (b) and there will be an arrangement with an Employer, indicate further details | Title at Responsible Entity:  honorary  adjunct |
| Intended grant arrangement:  affiliation agreement  subcontract to Employer |
| Relevant Employer: |
| Position at Employer: |
| Employer has an active ABN:  Yes |
| Employer has a physical & operational presence in WA:  Yes |
| Affiliated entities, position/title  *List all entities that the Innovation Fellow is employed by or affiliated with, other than the Responsible Entity or Employer listed above. Identify if adjunct or honorary position).* |  |
| Discipline/Profession |  |
| Clinician Profession  *Note: this is collected for statistical purposes only* | Not Applicable  Allied health and health sciences  Dentistry  Medical Practitioner  Nursing & Midwifery |
| Research career stage  *An Early-Career researcher has held their PhD for no more than 5 years from the date that their PhD was passed and a Mid-Career researcher no more than 10 years as at the time of application, taking into consideration any career disruptions as defined in the* [*NHMRC Relative to Opportunity Policy*](https://www.nhmrc.gov.au/about-us/nhmrc-policies-and-priorities)  *Note: this is collected for statistical purposes only* | Not applicable  Early-Career  Mid-Career  Post Mid-Career |
| Primary telephone number |  |
| Primary email address |  |
| Primarily based in WA  *Confirm that you will be based in WA for a minimum of 80% during the grant* | Yes |
| Completed the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course (or equivalent)  *Note: Although this training is for ‘research’ it contains insights which also have relevance to innovation activities* | Yes No  If applicable, equivalent course name: |
| Completed the free online 30 minute [Consumer & Community Involvement and Grant Writing](https://cciprogram.org/consumer-community-involvement-and-grant-writing-e-course/) course (or equivalent) | Yes No  If applicable, equivalent course name: |
| CV attached  *Maximum two pages* | Yes |

## Innovation Mentor

Insert an abridged (two-page maximum) Curriculum Vitae (CV), which includes key innovation achievements over the last 5 years. CVs can be inserted at the end of this application form.

Where possible, it is preferred that this person is different to the Fellowship Supervisor.

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| Entity (e.g. organisation) |  |
| Entity address |  |
| Position title |  |
| Discipline / Profession |  |
| Primary telephone number |  |
| Primary email address |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| CV attached  *Maximum two pages* | Yes |

## Fellowship Supervisor

Insert an abridged (two-page maximum) Curriculum Vitae (CV), which demonstrates content knowledge and expertise over the last 5 years of relevance to the Activity. CVs can be inserted at the end of this application form.

Where possible, it is preferred that this person is different to the Innovation Mentor.

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| Entity (e.g. organisation) |  |
| Entity address |  |
| Discipline / Profession |  |
| Primary telephone number |  |
| Primary email address |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| CV attached  *Maximum two pages* | Yes |

## Significance of the problem (20%)

Describe the following:

1. the health or medical problem that the innovation addresses
2. the relevance and scale of this problem in WA
3. the importance of addressing the problem in WA, and at a national and global level.

*[Maximum 300 words]*

|  |
| --- |
| a)  b)  c) |

## Proposed innovation (20%)

Describe the following:

1. the proposed innovation and how it is novel (new)
2. the justification for the selected maturity level of the innovation Activity, which must be within the range of IML 3 to IML 6 (refer to Appendix 1 of the Guidelines and Conditions)
3. the differentiation between the proposed innovation and any existing, emerging or competing processes, products and/or services.

*[Maximum 500 words]*

|  |
| --- |
| a)  b)  c) |

## Value proposition (15%)

Describe the following:

1. the potential impact of the proposed innovation on the problem in WA
2. the impact that the innovation will have on the health and/or wellbeing of the WA community
3. the economic, social and environmental benefits of the innovation to WA
4. the potential commercial value of the innovation, including market size and scalability, at the WA, national and global level, where applicable
5. the drivers for clinicians, patients, community and/or industry to adopt the innovation.

*[Maximum 400 words]*

|  |
| --- |
| a)  b)  c)  d)  e) |

## Activity plan (15%)

Describe the following:

1. the Activity that will be undertaken, including objectives, methodology, and realistic measures of expected outcomes
2. the contribution the Activity provides towards the proposed solution.

*Note: Assessment of the Activity plan includes the achievability of the proposed milestones and timeframes (as provided below) and the proposed budget to undertake the Activity and justification for budget items (as provided in the ‘Budget request’ section).*

*[Maximum 400 words]*

|  |
| --- |
| a)  b) |

List the major milestones for the Activity and their duration in months from grant commencement in the following table.

The Activity commences upon execution of a Grant Funding Agreement or Memorandum of Understanding (as appropriate). Include separate milestones as applicable, for example, ethics and governance approvals, employment of staff, data collection, participant recruitment, and data analysis.

*Note: If ethics/governance approval is required for the Activity, this must be achievable within the Activity period.*

| **No** | **Milestone**  *(insert additional rows as required in order of completion)* | **Milestone date**  *(in months from execution)* |
| --- | --- | --- |
| 0. | Execution of Grant Funding Agreement | 0 months |
| 1. | *e.g. recruitment of support personnel* | *e.g. 1 months from execution* |
| 2. |  | *e.g. 3 months from execution* |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

|  |  |
| --- | --- |
| Enter the duration of the Activity in months  *(Activity must be completed within a maximum of 12 months)* |  |

## Activity Lead (Innovation Fellow) track record and potential (10%)

Describe the following:

1. the contribution of the Activity Lead to the proposed Activity, including the specific responsibilities towards the delivery of the objectives, methodology and outcomes
2. the extent to which the Activity Lead’s expertise and experience will support the proposed Activity, and their ability to deliver the proposed solution
3. the clear and achievable goals for the Activity Lead’s innovation capability development during the Fellowship.

*[Maximum 250 words]*

|  |
| --- |
| a)  b)  c) |

## Supporting environment (10%)

Describe the following:

1. the knowledge, expertise and experience and innovation achievements of the Innovation Mentor
2. the contribution of the Innovation Mentor to the proposed Activity
3. the knowledge, expertise and experience of the Fellowship Supervisor of relevance to the Activity
4. the contribution of the Fellowship Supervisor to the proposed Activity
5. appropriate level of partner engagement and collaboration, during both the development of the proposal and the conduct of the Activity
6. access to technical resources, infrastructure, equipment and facilities and additional support personnel, if necessary.

*[Maximum 500 words]*

|  |
| --- |
| a)  b)  c)  d)  e)  f) |

## Consumer involvement (10%)

Describe the following:

1. how consumers (people with lived experience of a health issue, including patients and potential patients, carers and people who use health care services) have been involved in the development of the proposed Activity
2. the plan for ongoing engagement in the Activity, including their roles and how their lived experience perspectives will inform the Activity through formal and informal processes.

Refer to the ‘Consumer involvement’ section of the Guidelines and Conditions. Note it is encouraged that all team members complete the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course\* (or equivalent) and that the Activity Lead also completes the free online 30 minute [Consumer & Community Involvement and Grant Writing](https://cciprogram.org/consumer-community-involvement-and-grant-writing-e-course/) course before completion of this section.

*\* Although this training is for ‘research’ it contains insights which also have relevance to innovation activities.*

As an example for clarity, if the Activity relates to the development of a device to be used by a clinician on a patient, the clinician is not a consumer for the purposes of this application, but rather the patient or their carer are consumers.

*[Maximum 300 words]*

|  |
| --- |
| a)  b) |

Please provide details of each consumer representative involved in the development of this proposal and/or proposed to be involved in the Activity. Note that named consumers must be aware of and agree to the statements above and must provide certification if proposed to be involved in the Activity.

Insert tables as required.

|  |  |
| --- | --- |
| Title, First Name, SURNAME |  |
| Email address |  |
| Role in the development of this proposal (if applicable) |  |
| Role in this Activity  (if applicable) |  |

## Budget request

The total budget must not exceed $150,000 ex GST over a maximum of 12 months.

Requested FTE, salary level, costs and duration must reasonably reflect the proposed Activity and be directly attributable to the delivery of the proposed Activity.

List requested budget items in the table below, noting the following:

1. Fellow salary costs:
   1. *A maximum of $100,000 may be requested as salary (including on-costs) for the Fellow’s time.*
   2. *Salary costs must be in accordance with the Fellow’s employment conditions and the applicable FTE and duration and may include Award/Agreement increases and salary increments as appropriate. Salary requested must not result in payment of more than 1.0 FTE.*
   3. *Salary on-costs may be requested up to a maximum of 30%, noting that salaries paid by a WA public health system entity can only include superannuation as a salary on-cost.*
   4. *Salary costs and/or on-costs for long service leave, parental leave, sabbatical, severance and termination payments cannot be included.*
2. Innovation Activity costs:
   1. *A maximum of $50,000 may be requested.*
   2. *May include additional personnel, essential services, supplies, equipment and consumer involvement.*
   3. *For additional personnel, must comply with salary on-cost limits defined above.*
   4. *Travel will not be approved unless strongly justified as being essential to the undertaking of the Activity and must not include costs related to conference attendance.*
   5. *Equipment items must not exceed a total value of 10% of the budget request or $15,000, whichever is the lesser amount, and quotes for items must be attached to the application.*
   6. *Must not be used for Innovation Mentor or Fellowship Supervisor costs.*
   7. *Overhead charges (also referred to as indirect/infrastructure costs, e.g. utilities) may be requested up to a maximum 10% of the total budget, unless the Responsible Entity is a WA public health system entity, in which case overhead charges cannot be included in accordance with the Financial Management Manual s522 (grant funding administered by the Office of Medical Research and Innovation is exempt).*

| **Budget category and item description** | **Funding request**  ($ ex GST and $AUD) |
| --- | --- |
| 1. **Fellow salary costs**   *Up to $100,000* |  |
| Position title/role:  On-cost %: | Base salary: $  On-costs: $ |
| ***Subtotal Fellow salary Costs*** | ***$*** |
| 1. **Innovation Activity costs**   *Up to $50,000* |  |
| Supplies:  *(provide details of items required)* | $ |
| Consumer Involvement:  *(provide details)* | $ |
| Minor essential equipment:  *(provide details and attach quotes)* | $ |
| Information Technology:  *(provide details of non-standard items required)* | $ |
| Travel:  *(provide travel purpose, dates and location)* | $ |
| Support position salaries:  *(provide title/role and costs for each)* | $ |
| Other:  *(specify each item)* | $ |
| Overhead charges: (*Up to a maximum of 10% of the total of Fellow salary costs and the other Innovation Activity costs)*  *(provide details of how this is calculated)* | $ |
| ***Subtotal Innovation Activity Costs*** | ***$*** |
| **TOTAL**  *Must not exceed $150,000 ex GST* | **$** |

### Budget request justification - salaries

Provide a justification for any salaries in the ‘Budget request’ table.

For each person, the salary justification should specify:

1. Fellow or support position title/role
2. the full-time annual salary amount, and the basis for this
3. salary on-costs %, and the basis for this.

Additionally for support positions:

1. FTE and duration, and why this is appropriate
2. duties and how these contribute to the delivery of the innovation Activity outcomes
3. where this expenditure is not in WA, why this is necessary.

*[Maximum 250 words]*

|  |
| --- |
| a)  b)  c)  d)  e)  f) |

### Budget request justification – non-salary items

Provide a justification for all requested budget items, such as specific expertise or equipment, and where this expenditure is not in WA, explain if the item is not available in WA or if it is beneficial to WA for the item to be procured outside the State. For equipment items ensure quotes are attached.

*[Maximum 250 words]*

|  |
| --- |
|  |

## Other funding sources for this Activity

Please select one of the two options below:

I have no other current source of funding for any component of this Activity, and no funding applications planned or in progress for any component of this Activity; or

I have funding applications planned or in progress which overlap with the entirety of this Activity or a component of this Activity (details below).

*For multiple funding applications, please provide each in a separate table*.

|  |  |
| --- | --- |
| Funding Organisation |  |
| Funding Scheme/Round |  |
| Amount of funding requested  (ex GST and $AUD) |  |
| Describe the overlap with this Activity |  |
| Expected date of Award or Decision |  |

## Cited information

If applicable, provide bibliographic references to any publications or reports cited in the application. Please only include publications strictly pertinent to the application.

|  |
| --- |
|  |

## Assessors not to be approached

Provide the name(s) of any assessor(s) or organisation(s) you request not to be approached to assess this application (if applicable) to [DOH.OMRI@health.wa.gov.au](mailto:DOH.OMRI@health.wa.gov.au). This information will only be available to the Office of Medical Research and Innovation, and must be provided by the application closing date.

## Activity Lead (Innovation Fellow) certification

I certify that:

1. I commit to taking part in the Activity proposed in this application for the duration of the grant if successful
2. the information supplied by me on this form is complete, true and correct in every particular
3. I agree to abide by the *Guidelines and Conditions*
4. I agree to participate in an evaluation whether the application is successful or unsuccessful
5. I have discussed the likely impact of the Activity on participating organisations, and this Activity is acceptable to them
6. I have relevant permissions to use any third-party intellectual property required to deliver the innovation Activity and have Freedom to Operate for this Activity
7. I agree to obtain any research ethics and governance approvals that might be required for undertaking the funded Activity
8. I understand and agree that if the application is successful, that no further claim will be made on the Department of Health to cover any expenditure beyond the approved budget
9. I do not have overdue reporting obligations for any grant funding program administered by the Office of Medical Research and Innovation (including FHRI Fund programs) from any year (excludes authorised extensions)
10. I will advise if funding is awarded for any component of the Activity.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Signature** |  | **Date** |  |

## Innovation Mentor certification

I certify that:

1. I commit to undertaking the Innovation Mentor role as described in the *Guidelines and Conditions* and as proposed in this application for the duration of the Fellowship if successful
2. I have reviewed and endorse the application
3. the information supplied by me on this form is complete, true and correct in every particular
4. I agree to abide by the *Guidelines and Conditions*.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Organisation name** |  | | |
| **Signature** |  | **Date** |  |

## Fellowship Supervisor certification

I certify that:

1. I commit to undertaking the Fellowship Supervisor role as described in the Guidelines and Conditions and as proposed in this application for the duration of the Fellowship if successful
2. I have reviewed and endorse the application
3. the information supplied by me on this form is complete, true and correct in every particular
4. I will abide by the *Guidelines and Conditions*.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Organisation name** |  | | |
| **Signature** |  | **Date** |  |

## Consumer representative certification

I certify that:

1. I commit to taking part in the Activity proposed in this application for the duration of the grant if successful
2. I agree to abide by the *Guidelines and Conditions*
3. I agree to be contacted in relation to the grant, e.g. for evaluation of the grant funding program.

Insert additional tables as required.

### Consumer Representative 1

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Signature** |  | **Date** |  |

## Responsible Entity certification

I certify that:

1. I am an authorised representative of the Responsible Entity
2. all the eligibility criteria listed in the *Guidelines and Conditions* are met
3. the Fellow will have a position or title at the Responsible Entity for the period of the grant if successful
4. if the Activity Lead is not an employee of the Responsible Entity, evidence of an affiliation agreement with, or in-principle agreement for subcontracting to, the relevant Employer has been attached, where this evidence has not previously been provided to the Office of Medical Research and Innovation
5. the Responsible Entity endorses this application and confirms that the information supplied on this form is complete, true and correct in every particular
6. the Responsible Entity is willing to administer the grant if successful under the conditions specified in the *Guidelines and Conditions*, including the requirement to ensure that appropriate agreements are in place with the Fellow, team members and participating entities
7. the grant will not constitute the entire financial base of the Responsible Entity, i.e. the Responsible Entity has other external sources of income
8. the Department of Health will be notified immediately of any changes to eligibility or changes to the information originally provided in this application.

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

## Responsible Entity finance officer (or equivalent) certification

I certify that:

1. I am an authorised finance representative of the Responsible Entity
2. the budgeted costs in this application are true and correct and reflect the latest costing information available to me
3. amounts requested in the Budget are in Australian dollars and are exclusive of Australian GST
4. I understand that funding will only be made available for the scope of work described in the application, or any modifications to the scope of work approved in writing by the Department of Health. The Department of Health is not obliged to underwrite any costs beyond funding awarded through this Program.

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

**[Scan this QR code with your smart phone to go the WA Health website](http://www.health.wa.gov.au/)**

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