**Innovative Solutions - Digital Health**

# **Application Form**

##### Due by: 1:00 pm (AWST) Monday 29 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 |

## Funding request

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

|  |  |
| --- | --- |
| Amount requested (ex GST)  *IML of the proposed Activity:*   * *IML 3: $50,000 -$100,000* * *IML 4-6: $250,000-$500,000* | $ |

## Activity classification

|  |  |
| --- | --- |
| **Burden of Disease** (up to 2) state the disease groups and names that are most applicable 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)  *Available 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

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:  via affiliation agreement  subcontract to Employer |
| 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 Activity Lead 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 |

## Team members

Provide details for each of the team members involved in the Activity. This will include team members associated with the Responsible Entity, and any other participating organisations.

To demonstrate the capacity of the team and its suitability to conduct the Activity, insert an abridged (two-page maximum) CV of each team member, which includes key innovation achievements over the last 5 years. CVs can be inserted at the end of this application form.

Insert additional team member tables as required.

|  |  |
| --- | --- |
| **Team member 1** | |
| 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/) |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| Primary telephone number |  |
| Primary email address |  |
| 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: |
| 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 the problem in WA
3. the importance of addressing the problem in WA, and at a national and global level.

*[Maximum 500 words]*

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

## Proposed innovation (20%)

Describe the following:

1. the proposed digital health 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, and how this is appropriate for the funding requested and Activity duration proposed (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
4. the proposed risk identification and mitigation strategies.

*[Maximum 500 words]*

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

## 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 500 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 500 words]*

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

List the major milestones for the Activity and their duration in months 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 maximum of 12 months for IML 3, and 24 months for IML 4-6)* |  |

## Activity Lead 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.

*[Maximum 250 words]*

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

## Supporting environment (10%)

Describe the following:

1. the knowledge, expertise and experience of team members
2. the capacity and capability of the team to deliver the proposed Activity
3. appropriate level of partner engagement and collaboration, during both the development of the proposal and the conduct of the Activity
4. access to technical resources, infrastructure, equipment and facilities and additional support personnel, if necessary.

*[Maximum 500 words]*

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

## 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 be within the following ranges:

* *IML 3: $50,000 -$100,000*
* *IML 4-6: $250,000-$500,000*

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. Salary costs:
   1. *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.*
   2. *Salary costs and/or on-costs for long service leave, parental leave, sabbatical, severance and termination payments cannot be included.*
   3. *Funding is not intended to provide salary for the Activity Lead. An exemption to this rule may be requested, where it is deemed that this salary is crucial to the success of the Activity. Adequate justification must be provided. Determination of exemptions will be made on a case-by-case basis, at the discretion of the Office of Medical Research and Innovation.*
2. Non-salary costs:
   1. *Must only include essential services, supplies, equipment, consumer involvement and other expenses directly related to the Activity.*
   2. *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.*
   3. *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.*
3. Overhead charges:
   1. *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 in AUD) |
| --- | --- |
| 1. **Salary costs**   *Insert more rows if required* |  |
| Position title/role:  On-cost %: | Base salary: $  On-costs: $ |
| Position title/role:  On-cost %: | Base salary: $  On-costs: $ |
| ***Subtotal Salary Costs*** | ***$*** |
| 1. **Non-salary costs**   *Insert more rows if required* |  |
| Supplies:  *(provide details of items required)* | $ |
| Consumer Involvement:  *(provide details)* | $ |
| Equipment:  *(provide details and attach quotes)* | $ |
| Information Technology:  *(provide details of non-standard items required)* | $ |
| Travel:  *(provide travel purpose, dates and location)* | $ |
| Other:  *(specify each item)* | $ |
| ***Subtotal Non-salary Costs*** | ***$*** |
| 1. **Overhead charges**   *Up to a maximum of 10% of costs (1 + 2)* |  |
| *(provide details of how this is calculated)* | $ |
| **TOTAL**  *Must be in following ranges:*   * *IML 3: $50,000 -$100,000* * *IML 4-6: $250,000-$500,000* | **$** |

### Budget request justification – salaries

Provide a justification for any salaries in the ‘Budget request’ table. For each position title/role, the salary justification should specify:

1. name of person (if known)
2. position title/role
3. employing entity
4. the full-time annual salary amount, and the basis for this
5. salary on-costs %, and the basis for this
6. FTE and duration, and why this is appropriate
7. duties, and how these contribute to the delivery of Activity outcomes (if a Team member note that this is provided in the ‘Team members’ section)
8. where this expenditure is not in WA, explain why this is necessary
9. if the person is the Activity Lead, provide justification of how paying this salary is crucial to the success of the Activity (see note 1.3 above).

*[Maximum 250 words]*

|  |
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|  |

### 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]*

|  |
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|  |

## Submission to 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.

## Team certification

We certify that:

1. we commit to taking part in the Activity proposed in this application for the duration of the grant if successful
2. the information supplied by us on this form is complete, true and correct in every particular
3. we agree to abide by the *Guidelines and Conditions*
4. we agree to participate in an evaluation whether the application is successful or unsuccessful
5. we have discussed the likely impact of the Activity on participating organisations, and this Activity is acceptable to them
6. we 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. we agree to obtain any research ethics and governance approvals that might be required for undertaking the funded Activity
8. we 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. the Activity Lead does 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. we will advise if funding is awarded for any component of the Activity.

### Activity Lead

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

Other Team Members associated with the Responsible Entity and any other participating organisations.

Insert additional tables as required.

### Team Member 1

|  |  |  |  |
| --- | --- | --- | --- |
| **Full 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 Activity Lead 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 Activity Lead, 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 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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