**Innovation Challenge 2023 –**

**Generative Artificial Intelligence Applications**

# **Stage 1 Feasibility - Application Form**

##### Due by: 1:00 PM (AWST) Thursday 6 April 2023

* ***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.***

## Minimum Data Form

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| --- | --- |
| Minimum Data Form submission date*(Mandatory eligibility requirement)*  |  |

Provide details if anything on the Minimum Data Form has changed in this application.

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## Activity title

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## Challenge stream

Select the one stream which is most applicable.

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| --- |
| [ ]  1. health and medical research [ ]  2. health and medical innovation[ ]  3. healthcare service delivery [ ]  4. health and medical education and training |

## Activity summary

Provide a plain language summary of the proposal, including the aims, objectives, significance and expected benefits to the WA health and medical research and innovation sector. This summary may be used for publicity purposes.

*[Maximum 250 words]*

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## Funding request

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

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| Amount requested (ex GST)*Up to $50,000*  | $ |

## Responsible Entity

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| --- | --- |
| Name of Responsible Entity*Entity which would administer grant funds* |  |
| ABN |  |
| Address*Must have a physical and operational presence in WA* |  |
| Contact officer name*Person responsible for grant administration* |  |
| Contact officer position |  |
| Contact officer email address |  |

## Activity Lead

Provide the details of the Activity Lead. Insert an abridged (two-page maximum) Curriculum Vitae (CV) which includes key publications from the last 5 years (where applicable). CVs can be inserted at the end of this application form.

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| ORCiD (if registered) |  |
| Citizenship/residency status | [ ]  Australian citizen [ ]  Australia permanent resident[ ]  New Zealand citizen [ ]  appropriate work visa |
| Grant arrangement*Refer to the ‘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: |
| 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: |
| Employer has a physical & operational presence in WA:[ ]  Yes  |
| Affiliated entities, position/title*List all entities that the Activity Lead is affiliated with, other than the Responsible Entity or Employer listed above. Identify if adjunct or honorary position.* |  |
| Discipline/Profession |  |
| 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) | [ ]  Early-Career [ ]  Mid-Career[ ]  Post Mid-Career[ ]  No postgraduate degree |
| 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 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course | [ ]  Yes [ ] No |
| 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 publications from the last 5 years (where applicable). CVs can be inserted at the end of this application form.

Insert additional team member tables as required.

|  |
| --- |
| **Team member 1** |
| Title, First name, SURNAME |  |
| ORCiD (if registered) |  |
| Role in this Activity |  |
| Time commitment to this Activity  |  hours/week |
| Primary telephone number |  |
| Primary email address |  |
| Completed the free 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course | [ ]  Yes [ ] No |
| CV attached *Maximum two pages* | [ ]  Yes |

## Significance of the problem (20%)

Describe the following:

1. The problem that the proposed activity addresses.
2. The impact of the problem on the selected health and medical stream.
3. The relevance and scale of the problem in WA.
4. The importance of addressing the problem in WA, and at a national and global level.

*[Maximum 500 words]*

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## Proposed solution (30%)

Describe the following:

1. The appropriateness of the Generative AI solution to address the stated problem.
2. The impact that the solution will have on the identified problem.
3. The economic, social and environmental benefits of the solution to WA.
4. The weaknesses or threats of the AI technology proposed for this solution.
5. The proposed risk identification and mitigation strategies.

*[Maximum 500 words]*

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## Activity plan (20%)

Describe the following:

1. The activity that will undertaken, including objectives, methodology, and realistic measures of expected outcomes
2. The contribution the activity provides towards the proposed solution.
3. The proposed budget to undertake the activity and justification for budget items, including any proposed salary components.

 *[Maximum 500 words]*

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List the major milestones for the Activity and their duration in months.

The activity must be completed within a 6-month period, which commences once a Grant Funding Agreement, or MOU, is executed.

*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)* | **Milestone date***(in months from execution)* |
| --- | --- | --- |
| 1. | *e.g. Agreement execution* | *0 months* |
| 2. | *e.g. Raw data validation complete* | *e.g. 2 months* |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

## 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 above objectives, methodology and outcomes
2. The extent to which the Activity Lead’s expertise and experience will support the proposed activity.
3. The extent to which the Activity Lead demonstrates the ability to deliver the proposed solution.
4. The extent to which the Activity Lead demonstrates clear and achievable goals with regard to their Generative AI capability development during the activity.

Where appropriate, consideration must be given to the [NHMRC Relative to Opportunity Policy.](https://www.nhmrc.gov.au/about-us/nhmrc-policies-and-priorities)

*[Maximum 500 words]*

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## Supporting environment (10%)

Describe the following:

1. The knowledge, expertise and experience of activity team members.
2. The capacity and capability of the activity 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]*

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## Consumer involvement (10%)

Describe the following:

1. How consumers (e.g. patients, carers, community members with a lived experience of a health issue) have been involved in the development of the proposed activity.
2. The plan for ongoing consumer 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.

 *[Maximum 500 words]*

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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

| **Budget item*****(insert additional rows as required)*** | **Budget requested*****(excluding GST and in Australian Dollars)*** |
| --- | --- |
|  |  |
|  |  |
|  |  |
| **Total budget***Up to $50,000*  |  |

## Budget request justification - salaries

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

1. name of employee
2. FTE or fractional, and why this is appropriate
3. duties, and how these contribute to the delivery of activity outcomes
4. the annual salary amount, and the basis for this
5. other salary funding sources.

*[Maximum 200 words]*

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## Budget request justification – non-salary items

Provide a justification for any requested budget items (other than salary), such as specific expertise or equipment, and where this expenditure is not in WA explain why this is necessary.

*[Maximum 200 words]*

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## Submission to other funding sources for this activity

List any other funding source(s) and the amount(s) requested. Include applications already submitted and planned submissions. These must complement, but not duplicate, the work for which the funding is requested. The Activity must not be dependent on the receipt of these other funding sources.

*[Maximum 250 words]*

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## Bibliographic references

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

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## Team certification

We certify that:

1. we commit to taking part in the activities 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 agree to obtain any research ethics and governance approvals that might be required for undertaking funded activities
7. 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
8. no team members have overdue reporting obligations for any other funding programs administered by OMRI (including FHRI Fund Programs)
9. an OMRI or FHRI Fund grant has not been awarded for the same activity
10. if successful, the Activity Lead or a suitable team member will submit an abstract and attend the annual Science on the Swan conference after the first year of the grant.

### 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 activities 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 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. the Activity Lead will have a position or title at the Responsible Entity for the period of the grant if successful
3. the Responsible Entity endorses this application, confirms that the information supplied on this form is complete, true and correct in every particular
4. the Responsible Entity is willing to administer the grant 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
5. the grant does not constitute the entire financial base of the Responsible Entity
6. the Department of Health will be notified immediately of any changes to the applicant’s eligibility or changes to the information originally provided in this application.

|  |  |
| --- | --- |
| **Title, First Name, SURNAME** |  |
| **Position** |  |
| **Signature** |  | **Date** |  |
| **Telephone number** |  |
| **Email address** |  |

### 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 claimed 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 with any modifications approved by the Department of Health. The Department of Health is not obliged to underwrite any costs beyond funding awarded through this Program.

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| --- | --- |
| **Full Name** |  |
| **Position** |  |
| **Signature** |  | **Date** |  |
| **Telephone number** |  |
| **Email address** |  |

Where different to the officer named above, please provide contact details for the person responsible for the payment of funds and financial acquittal reporting for this grant.

|  |  |
| --- | --- |
| **Full Name** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address** |  |

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