**Innovation Seed Fund 2023-24**

# **Application Form**

**Due by: 1:00 pm (AWST) Tuesday 12 December 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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## Activity summary

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

*[Maximum 250 words]*

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## Innovation Maturity Level (IML)

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| --- | --- |
| Select the IML of the proposed innovation Activity*Must be within the range of IML 3 to IML 7 (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[ ] IML 7 – Confirmatory Validation \**\* subject to meeting the eligibility criterion regarding matched funding/investment* |

## 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*
* *IML 7: $500,000-$750,000*
 | $ |

## Matched funding/investment

For IML 7 activities, it must be demonstrated that funding/investment from non-governmentsources has been received**,** that at least matches the amount of funding requested.

*Note: Matching funding/investment must not be through entities that are part of an industry that produces products or services that may contribute to poor physical health or mental wellbeing of the community.*

If this information is considered ‘Commercial in Confidence’ it may be provided in a separate attachment marked as such and for the attention of the Office of Medical Research and Innovation only. In this case, please indicate that this applies in the ‘Non-government entity’ box below and enter the total matched funding/investment amount in the ‘Funding/Investment Amount received’ box.

Insert additional rows as required.

|  |  |
| --- | --- |
| **Non-government entity** | **Funding/Investment Amount received***($ ex GST and in Australian dollars)* |
|  | $ |

## Activity classification

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| **Burden of Disease** (indicate the disease that is most applicable)*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**Note: this is collected for statistical purposes only* |  |
| **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: this is collected for statistical purposes only* | 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 name*Person responsible for grant post award (different to Activity Lead unless Sole Trader)* |  |
| 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 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: |
| 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 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) | [ ]  Yes [ ] NoIf 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 (where applicable). CVs can be inserted at the end of this application form.

Insert additional team member tables as required.

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| **Team member 1** |
| Title, First name, SURNAME |  |
| 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) | [ ]  Yes [ ] NoIf applicable, equivalent course name: |
| CV attached *Maximum two pages* | [ ]  Yes |

## Significance of the Problem (15%)

Describe the following:

1. the 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 250 words]*

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## Proposed innovation and its maturity level (15%)

Describe the following:

1. the proposed innovation and how it is novel (new)
2. the maturity level of the innovation Activity, which must be within the range of IML 3 to IML 7 and be 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 or emerging competing processes, products and/or services
4. the technical merit (proof of concept) of the innovation, including key data that support the innovation.

*[Maximum 500 words]*

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## 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
5. the advantage of the innovation over any competing processes, products and/or services
6. the drivers for clinicians, patients, community and/or industry to adopt the innovation.

*[Maximum 500 words]*

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## Activity plan (15%)

**Note: The Activity must be completed within 12 months for IML 3, and 24 months for IML 4-7.**

Describe the Activity plan including:

1. the activity that will be undertaken, including objectives, methodology and realistic measures of outcomes
2. how the activity will contribute to validation or de-risking of the innovation
3. how the activity will improve the commercial potential of the innovation and drive investor/partner interest to get the innovation to market.

*[Maximum 500 words]*

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

Milestone 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)* | **Milestone date** *(in months from execution)* |
| --- | --- | --- |
| 1. | *e.g. prepare and submit ethics application* | *e.g. 1 month* |
| 2. | *e.g. recruitment of support personnel* | *e.g. 2 months* |
| 3. | *e.g. obtain ethics and governance approvals* | *e.g. 3 months* |
| 4. |  |  |
| 5. |  |  |

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| Enter the duration of the Activity in months*The Activity must be completed within 12 months for IML 3, and 24 months for IML 4-7* |  |

## Capacity, capability and resources (10%)

Describe the following:

1. contribution of the Activity Lead and each Team Member to the proposed activity
2. any collaborations with WA health service providers (public and/or private) and WA industry
3. access to technical resources, infrastructure, equipment and facilities and additional support personnel, if necessary.

*[Maximum 250 words]*

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## Intellectual Property (10%)

Describe the IP position and strategy, including:

1. any existing patent filings, including stage and priority dates
2. names of the key inventors and the IP ownership structure
3. the IP strategy for protection of the innovation and any potential new IP during and beyond the funding period.

*[Maximum 250 words]*

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## 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.

*[Maximum 250 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 additional tables as required.

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

## Anticipated commercialisation pathway and strategy (10%)

Describe the following:

1. the anticipated commercialisation pathway for the innovation from its current stage to market, including possible timeframes for each stage and go/no-go decision points
2. the anticipated funding strategy to take the innovation to market
3. the anticipated model for the generation of financial returns through commercialisation of the innovation
4. potential investors and/or natural partners/acquirers of the innovation.

*[Maximum 500 words]*

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## Budget details

List requested budget items in the table below.

The total budget must be within the following ranges:

* *IML 3: $50,000 -$100,000*
* *IML 4-6: $250,000-$500,000*
* *IML 7: $500,000-$750,000\**

*\* subject to meeting the eligibility criterion regarding matched funding/investment*

Please note the following with regards to salary costs:

* *Salary on-costs may be requested to up to a maximum of 30%, noting that WA public health system applicants must claim salary on-costs in accordance with the WA Health Financial Management Manual s521 ‘Internal Salary Recoup (within WA Health entities)’ table.*

Please note the following with regards to non-salary costs:

* *Include essential services, supplies, equipment, consumer involvement and other expenses directly related to the Activity.*
* *Travel will not be approved unless strongly justified as being essential to the undertaking of the Activity.*
* *Equipment may be requested up to a maximum of $10,000 in total and quotes for items must be attached to the application.*

Please note the following with regards to overhead charges:

* *Overhead charges may be requested up to a maximum of 10% of the total budget, noting that WA public health system applicants cannot claim standard overhead charges in accordance with the Financial Management Manual s522 (OMRI is an exempt organisation).*

| **Budget item description** | **Funding request**($ ex GST and in Australian dollars) |
| --- | --- |
| **Salary costs** *Insert more rows if required* |  |
| *Position title/role:*  | salary: $on-costs: $ |
| *Position title/role:*  | salary: $on-costs: $ |
| **Non-salary costs***Insert more rows if required* |  |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
| **Overhead charges***Up to a maximum of 10%* |  |
|  | $ |
| **TOTAL***Must be in following ranges:** *IML 3: $50,000 -$100,000*
* *IML 4-6: $250,000-$500,000*
* *IML 7: $500,000-$750,000*
 |  |

### Budget request justification – salaries

Provide a justification for any salary costs in the ‘Budget request’ table. For each position 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
6. where this expenditure is not in WA, explain why this is necessary.

*Note: 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 project. Adequate justification must be provided. Determination of exemptions will be made on a case-by-case basis, at the discretion of OMRI.*

*[Maximum 250 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 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 from outside the State.

*[Maximum 250 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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## 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.

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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 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 funded activities
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. no team members have overdue reporting obligations for any other funding programs administered by OMRI (including FHRI Fund Programs)
10. an OMRI or FHRI Fund grant has not been awarded for the same activity
11. if successful, the Activity Lead, or a suitable team member, will consider submitting an abstract to, and attending, the annual Science on the Swan conference following the first year of the grant, However, this will not apply if the submission of an abstract with breach confidentiality provisions, restrict the ability to publish or to obtain patents.

### 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 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.
4. the grant does not constitute the entire financial base of the Responsible Entity.
5. 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 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
5. where this application relates to a request for funding for IML 7 activities, funding/investment from non-government sources has been received, that at least matches the amount of funding requested, and that this matching funding/investment has not been received through entities that are part of an industry that produces products or services that may contribute to poor physical health or mental wellbeing of the community.

|  |  |
| --- | --- |
| **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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on request for a person with a disability.**

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