**Innovation Seed Fund 2022**

# **Application Form**

**Application Period closes: 1:00pm (AWST), Monday 2 May 2022**

***When completing this Application Form refer to the*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities/Innovation-Seed-Fund-2022)***, which include application instructions.***

## Activity title

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## Activity summary

Provide a plain language summary of the innovation proposal, including the significant problem of relevance to Western Australia (WA), the innovation activity, how it will address the problem and the expected benefits of the innovation.

*[Maximum 250 words]*

*Note that this summary may be used for publicity purposes.*

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## Innovation maturity level

|  |  |
| --- | --- |
| State the current maturity level of the innovation  *Must be at least IML 3, and no further advanced than IML 6 (Refer to Appendix 1 of the Guidelines and Conditions)* | IML 3 – Proof of Concept  IML 4 – Proof of Feasibility  IML 5 – Proof of Value  IML 6 – Preliminary Validation |

## Funding request

|  |  |
| --- | --- |
| Amount requested (ex GST)  *Between $250,000 and $500,000* | $ |

## Responsible Entity

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| --- | --- |
| Responsible Entity Name  *Entity which will administer grant funds*  *Provide details if employment scenario (c) applies as outlined in Section 4 of the Guidelines and Conditions* |  |
| Responsible Entity Address  *Must be WA-based* |  |
| Responsible Entity ABN |  |
| Contact officer name |  |
| Contact officer email address |  |

## Innovation Lead

Provide the details of the Innovation Lead.

Include an abridged (2-page maximum) Curriculum Vitae (CV), which includes significant innovation achievements over the last 5 years. This can be inserted at the end of this application form in the nominated section (not as a separate file).

|  |  |
| --- | --- |
| Title, First Name, SURNAME |  |
| Citizenship/Residency status  *Australian Citizen or Permanent Resident* |  |
| Affiliated Entities  *Entities with which the Innovation Lead may be affiliated, other than the Responsible Entity* |  |
| Discipline/Profession |  |
| Position title |  |
| Telephone number |  |
| Email address |  |
| Time contribution to this activity (hours per week) |  |
| CV included  *Maximum two pages* | Yes |

## Other Innovation Team Members

Associated with the Responsible Entity and any other participating entities.

Provide details regarding the capacity of the team and its suitability to undertake the activity. For each team member provide a short description highlighting their expertise and experience that enables them to contribute to the delivery of the activity, and any significant innovation achievements over the last 5 years.

*Insert additional tables as required.*

|  |  |
| --- | --- |
| **Team member 1** | |
| Title, First Name, SURNAME |  |
| Discipline / Profession |  |
| Position title |  |
| Entity |  |
| Telephone number |  |
| Email address |  |
| Role in this activity |  |
| Time contribution to this activity (hours per week) |  |
| Short summary of expertise, experience and innovation achievements over the last 5 years |  |

## Significance of the problem

Describe the following:

1. the problem that the innovation addresses
2. the relevance and scale of the problem in WA (e.g. number of patients for a given segment)
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

Describe the following:

1. the proposed innovation and how it is novel (new)
2. the current maturity level of the innovation, which must be at least IML 3 but no further advanced than IML 6 (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 validate the innovation.

*[Maximum 400 words]*

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## Value proposition

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 400 words]*

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## Proposed activity

Describe the following:

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 400 words]*

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List the major milestones for the activity, and their duration. The activity must be completed within a 2-year 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 2-year activity period.*

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| **Activity Milestones** | **Timeframe**  *(maximum 2 years)* |
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## Capacity, capability and resources

Describe the following:

1. contribution of the Innovation 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

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

Describe the following:

1. how consumers (e.g. patients, carers, community members) have been involved in the development of the innovation to date, including 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 delivery. For guidance refer to Section 8 of the Guidelines and Conditions.

*[Maximum 250 words]*

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

*Additional tables can be inserted as required.*

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

## Anticipated commercialisation pathway and strategy

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 400 words]*

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## Budget request

List requested budget items. The total budget must be between $250,000 and $500,000 over a maximum of two years.

Please note the following with regards to salary costs:

* *A maximum of $150,000 per annum for Full Time Equivalent (FTE) salary, including on-costs, may be requested for each individual, with this limit adjusted to a pro rata amount for fractional FTE.*
* *Salary on-costs may be requested to up to 30%. However, WA public health system applicants must claim 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 overhead charges:

* *Overhead charges (also referred to as indirect/infrastructure costs, e.g. utilities) may be requested up to 10% of the total budget. However, WA public health system applicants cannot claim standard overhead charges, as per the Financial Management Manual s522 (exempt organisation).*

| **Budget Item** | **Funding request**  ($ ex GST) | | |
| --- | --- | --- | --- |
| **Salary costs**  *Insert more rows if required* | **Year 1** | **Year 2** | **Total** |
| *Position title/role:* | salary:  on-costs: | salary:  on-costs: |  |
| *Position title/role:* | salary:  on-costs: | salary:  on-costs: |  |
| **Innovation activity costs**  *Insert more rows if required* | **Year 1** | **Year 2** | **Total** |
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| **Overhead charges** | **Year 1** | **Year 2** | **Total** |
|  |  |  |  |
| **TOTAL**  *Must be between $250,000 and $500,000 (ex GST)* |  |  |  |

## Budget request justification – salary costs

Provide a justification for any salary costs in the ‘Budget request’ table. For each position specify:

1. position title/role
2. FTE, and why this is appropriate
3. the full-time annual salary amount, and the basis for this
4. salary on-costs %, and the basis for this
5. duties, and how these contribute to the delivery of the innovation activity outcomes.

*[Maximum 250 words]*

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## Budget request justification – innovation activity costs

Provide a justification for each innovation activity cost, and where expenditure is not in WA explain why this is necessary.

*[Maximum 250 words]*

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## Other funding sources or in-kind support for this activity

List any other funding sources and amounts obtained or requested. If requested, indicate the status, e.g. planned/submitted.

*Note:*

* *Any other funding must be to complement, but not duplicate, the work for which the seed funding is requested.*
* *The Seed Fund activity must not be dependent on the receipt of requested funding sources.*

List any relevant in-kind support.

*[Maximum 250 words]*

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## Cited information

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

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## Innovation Lead abridged CV

Insert an abridged (two-page maximum) CV, which includes significant innovation achievements over the last 5 years.

*Insert here*

## Innovation Team certification

We certify that:

1. We will take part in the activities proposed in this application.
2. To the best of our knowledge, the information supplied by us on this form is complete, true and correct in every particular.
3. We will abide by the *Innovation Seed Fund 2022 Guidelines and Conditions.*
4. We have discussed the likely impact of the activity on other relevant entities, and this activity is acceptable to them.
5. 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.
6. We will obtain the relevant approvals before commencement of the activity.
7. We understand and agree that, if the application is successful, no further claim will be made on the Department of Health to cover any expenditure beyond the approved budget.
8. No member of the Innovation Team has outstanding reporting obligations for any other funding program administered by RIO (including FHRI Fund Programs).

**Innovation Lead**

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

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

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 innovation activity if successful.
2. I agree to abide by the *Innovation Seed Fund 2022 Guidelines and Conditions.*

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 Innovation Lead will be employed by the Responsible Entity (in accordance with the definitions in Section 4 Eligibility of the Guidelines and Conditions) and reside in WA for the period of the grant.
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 will administer the grant under the conditions specified in the *Innovation Seed Fund 2022 Guidelines and Conditions*.
5. The Responsible Entity has a physical and operational presence in WA.
6. The grant funding does not constitute the entire financial base of the Responsible Entity.
7. The Department of Health will be notified immediately of any changes to the Responsible Entity, Innovation Lead or other information originally provided in this application.

|  |  |
| --- | --- |
| **Full Name** |  |
| **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 GST and are in Australian Dollars.
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 will not underwrite any recurrent or capital 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 activity.

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

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

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