**FHRI Fund Consumer and Community Involvement Support**

# **Application Form**

##### Due by: 1:00 pm (AWST) Wednesday 18 December 2024

* ***Please refer to the relevant*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities) ***which include application instructions.***
* ***Activity Leads 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]*

|  |
| --- |
|  |

## Funding request

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

|  |  |
| --- | --- |
| Amount requested (ex GST)  *Up to $25,000* | $ |

## 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:  Phone: |
| Contact officer post-award  *(different to Activity Lead unless not possible e.g. Sole Trader)* | Same as pre-award above  **or**  Name:  Position:  Email:  Phone: |

## Activity Lead

Insert an abridged (two-page maximum) Curriculum Vitae (CV) which includes key research/ 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 |
| Primarily based in WA  *Confirm that you will physically reside in WA for a minimum of 80% during the grant* | Yes |
| 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: |
| 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 |
| Is this person also the CCI Lead?  *The CCI Lead is the person primarily undertaking the CCI activities and may differ from the Activity Lead* | Yes No  *If no, please fill out the table in Section 6* |

**Grant Arrangement**

|  |  |
| --- | --- |
| Relationship to Responsible Entity  *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 |
| Employer: |
| Position at Employer: |
| Employer has an active ABN:  Yes |
| Employer has a physical & operational presence in WA:  Yes |

**Other employment and affiliations**

List all the entities that the Activity Lead is employed by or has an affiliation with, other than the Responsible Entity or Employer listed above. Identify if an adjunct or honorary title or a Clinical Academic position. Add rows if necessary.

|  |  |  |
| --- | --- | --- |
| **Entity** | **Position/Title** | **Paid** Y/N |
|  |  |  |
|  |  |  |
|  |  |  |

**Other information**

|  |  |
| --- | --- |
| Discipline/Profession |  |
| Clinician Profession  *Note: this is collected for statistical purposes only* | Allied health and health sciences  Dentistry  Medical Practitioner  Nursing & Midwifery  Non-clinician |
| 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* | Early-Career  Mid-Career  Post Mid-Career  No postgraduate degree |
| Postgraduate research degree  *The nominated years since award of degree/years of research experience must align with the justification below.* | PhD  Masters by Research  None  Years since award of degree: \_\_\_\_\_\_\_\_  If None, years of research experience: \_\_\_\_\_\_\_\_ |
| Within which area are you located | Perth metropolitan  Regional and remote |

## 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 research/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.

|  |  |
| --- | --- |
| CCI Lead (if different to the Activity Lead) | |
| 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/) |  |
| Primarily based in WA  *Confirm that you will physically reside in WA for a minimum of 80% during the grant* | Yes |
| Employer(s) |  |
| Position(s) |  |
| 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 |

|  |  |
| --- | --- |
| **Team member 1** | |
| Title (e.g. Dr, Ms), First name, SURNAME |  |
| ORCiD (research only)  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  |
| Employer(s) |  |
| Position(s) |  |
| 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 |

## Activity classification

|  |  |
| --- | --- |
| **Broad Research Area** *(select one)*  *Refer to National Health and Medical Research Council* [*website*](https://www.nhmrc.gov.au/about-us/resources/australian-standard-research-classifications-and-research-keywords?mc_cid=8d59f951bb&mc_eid=e758823e42) *for description of broad research areas.* | **​**  Basic scienceresearch  **​**  Clinical medicine and science research  **​**  Health services research  **​**  Public health research |
| Field of Research (FoR)  *Australian and New Zealand Standard Research Classification, 2020 downloadable from the Australian Bureau of Statistics* [*website*](https://www.abs.gov.au/statistics/classifications/australian-and-new-zealand-standard-research-classification-anzsrc/latest-release)*.* | Primary FoR *(mandatory):*   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |   Secondary FoR(s) *(optional):*   |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| **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)  *Must be selected from NHMRC*  [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Researcher > My Applications > Keyword Library* | 1.  2.  3.  4.  5. |

## Significance of the Activity (20%)

***For Option A:*** *applications to support CCI activities to inform research and/or innovation priorities and ideas for future research and/or innovation activities.*

Outline the planned FHRI Fund, NHMRC or MRFF grant applications you intend to apply for that are relevant to this Activity.

***For Option B:*** *(i) applications to support CCI activities to develop and write a planned FHRI Fund or national research or innovation grant application, or (ii) CCI activities in an existing FHRI Fund or national research or innovation activity where CCI activity is not already funded.*

Describe the following:

1. the significance of the proposed issue to the community according to the community
2. how the proposed Activity will address the issue described above
3. the expected benefits to the WA community (e.g. reduce inequities, improved health outcomes, economic, social and environmental benefits)
4. the impact on existing programs and CCI activities that are currently operating in this area.

*[Maximum 300 words]*

|  |
| --- |
|  |

## Activity plan (50%)

Indicate whether your consumer and community target group represent:

*(multiple options can be selected)*

☐ Children and young people ☐ Aboriginal people

☐ People with disability ☐ Culturally and linguistically diverse people

☐ LGBTQIA+ ☐ People with mental health problems and/or mental illness

Describe the Activity plan, including:

1. the Activity objectives, ensuring these are specific, measurable, attainable, relevant and time-bound
2. how consumers and/or community members will be involved to achieve the objective of the Activity
3. the proposed CCI activities and methodologies that will be undertaken, including techniques, target group(s), measures to be used and proposed locations where the Activity will be undertaken
4. any grant applications that are planned and/or relevant to this CCI activity
5. an achievable timeline.

*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 1000 words]*

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

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

The Activity starts upon execution of a Grant Funding Agreement. Include separate milestones as applicable.

*Note: If ethics/governance approval is required for the Activity, this must be achievable within the Activity period and approval dates do not affect the Activity start date.*

| **No** | **Milestone**  *(insert additional rows as required in order of completion)* | **Milestone date**  *(in months from start date)* |
| --- | --- | --- |
| 0. | Execution of Grant Funding Agreement | 0 months |
| 1. | *e.g. consumer and community member meetings* | *e.g. 1 month from start date* |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |

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

## Activity Lead and team track record and potential (20%)

Describe the following:

1. the Activity Lead’s track record of translational research and/or innovation activities
2. the Activity Lead’s track record of CCI
3. the Activity Lead’s capacity and plan for meeting the deliverables (as outlined in the ‘Program description’ section of the Guidelines and Conditions)
4. the role of the CCI Lead (if applicable) and collective gain and experience of the team conducting the Activity.

With regards to a) and b), 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]*

|  |
| --- |
|  |

## Consumers

Please provide details of each consumer representative (separate to the CCI Lead) 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.

|  |  |
| --- | --- |
| Full name |  |
| Email address |  |
| Role in the development of this proposal (if applicable) |  |
| Role in this Activity  (if applicable) |  |

## Budget request (10%)

The total budget must be up to $25,000 ex GST over a maximum of 12 months.

Requested costs 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. Costs:
   1. *Must only include CCI Lead payments, expenses associated with hosting CCI events, honorariums, consumer payments, other supplies and catering for CCI activities and travel 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.*
2. 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** | **Year 1 request**  (AUD ex GST) |
| --- | --- |
| 1. **Costs**   *Insert more rows if required* |  |
| CCI event supplies and catering:  *(provide details of items required)* | $ |
| Honoraria and consumer payments:  *(provide details)* | $ |
| Travel:  *(provide travel purpose, dates and location)* | $ |
| Other:  *(specify each item)* | $ |
| ***Subtotal costs*** | ***$*** |
| 1. **Overhead charges**   *Up to a maximum of 10% of costs* |  |
| *(provide details here of how overheads are calculated)* | $ |
| **TOTAL**  *Must be no more than $25,000 ex GST* | **$** |

### Budget request justification

Provide a justification for all requested budget items 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.

*[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 |  |

## 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.

|  |
| --- |
|  |

## 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 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. if the Activity Lead is employed by the WA public health system and the Responsible Entity is not the WA public health system entity (includes Clinical Academics where applicable), the Activity Lead will [register](http://coi.hdwa.health.wa.gov.au/) a Conflict of Interest for this grant in accordance with the Department of Health [Managing Conflicts of Interest Policy](https://www.health.wa.gov.au/About-us/Policy-frameworks/Integrity/Mandatory-requirements/Managing-Conflicts-of-Interest-Policy) that addresses how the Activity Lead intends to ensure WA Health intellectual property (IP) is protected
10. 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)
11. we will advise if any other 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** |  |

## CCI Lead and 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 and promotion.

### CCI Lead (if applicable)

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

### Consumer Representative 1 *(insert additional tables as required)*

|  |  |  |  |
| --- | --- | --- | --- |
| **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 Responsible Entity or other entities that fund or are involved in the Activity are not part of. an industry that produces products or services that may contribute to poor physical health or mental wellbeing of the community
9. 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/)**

**This document can be made available in alternative formats   
on request for a person with a disability.**

© Department of Health 2024

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.