**Western Australia (WA) Cohort Studies -**

**Research Support Program**

**(WACS-RSP)**

# **Application Form**

##### Due by: 1:00 PM (AWST) Tuesday 26 September 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 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.

|  |  |
| --- | --- |
| Amount requested (ex GST)  *Up to $1,000,000* | $ |

## Activity funding request summary

The information provided below must align with the ‘Budget details’ table. All amounts must be excluding GST.

|  |  |
| --- | --- |
| Activity funding request  *No more than $1,000,000 can be requested for the Activity*  *Overhead costs must be maximum 10% of the total funding request.* | Salary costs $  Activity costs $  Travel costs $  Equipment costs $  Overhead costs $ |
| Total Activity funding request  *Maximum $1,000,00 for the 3.5-year period* | $ |

## Research 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** (select one disease)  *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* |  |
| **Research Keywords** (up to 5)  *Available from NHMRC*  [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Researcher > My Applications > Keyword Library* | 1.  2.  3.  4.  5. |

## Responsible Entity

|  |  |
| --- | --- |
| Name of Responsible Entity  *Entity which would administer grant funds*  *Must be a WA university, WA research institute, WA public health service provider or WA public-private partnership provider* |  |
| 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  *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 affiliated with, other than the Responsible Entity or Employer listed above. Identify if adjunct or honorary position.* |  |
| Discipline/Profession |  |
| Clinician Profession | 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) | 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 online 30 minutes [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 |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| Primary telephone number |  |
| Primary email address |  |
| Completed the free online 30 minutes  [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 Activity (30%)

Applications must address contemporary challenges or needs faced by the WA community. Research projects should aim to leverage the Busselton Health Study, ORIGINS Project and/or Raine Study to demonstrate their use and applicability and address unmet needs that complement the FHRI Fund Strategy Focus Areas (i.e. Aboriginal, rural, and remote health; Burden of diseases; Living with COVID-19 and Long-Covid; and Mental Health).

Describe the following:

1. significance to the FHRI Fund Priorities Goals and/or Focus Areas
2. the issue and its significance to the health of the WA community (e.g. incidence, prevalence, burden of disease, impact on delivery or cost of health service)
3. how the proposed Activity will address the issue described above
4. the expected benefits to the WA community (e.g. reduce inequities, economic, social and environmental benefits)
5. planned steps for the translation and/or implementation of findings and the activity timeframes for translational impacts
6. future plans for the activity. For example, a possible extension of the Activity to a broader geographical area, population or to other disciplines.

*[Maximum 1000 words]*

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## Research quality and Activity plan (30%)

Describe the Activity plan including:

1. the hypothesis, questions, and objectives. Ensure objectives are specific, measurable, attainable, relevant and time-bound
2. the methodology, including techniques, target group(s), use of cohort study data and/or information, a realistic sample size and measures to be used
3. a list of all locations where the Activity will be undertaken, ethics and governance approvals and agreements that will be required before the Activity can proceed (if any research is undertaken at a WA public health system site or involves a WA public health system employee, ethics approval must be sought from a WA Health HREC, as per the Department of Health [Research Governance Framework](https://rgs.health.wa.gov.au/Pages/Research-Governance-Framework.aspx))
4. an achievable timeline

*[Maximum 2000 words]*

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

Milestone activity commences upon execution of a Grant Funding Agreement or Memorandum of Understanding (as appropriate). Include as separate milestones ethics and governance approvals, employment of staff, data collection, participant recruitment (as applicable), data analysis and submission of publications.

The Activity must be completed within 41 months.

| **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. |  |  |

## Consumer involvement (15%)

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 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) |  |

## Team capacity, capability and resources (25%)

Describe the following:

1. the Activity Lead’s capacity and plan for meeting the deliverables (refer to the ‘Selection process’ section of the Guidelines and Conditions)
2. collective gain of the team to the Activity, including potential for new research capacity, time allocated to conduct the project, provision of appropriate supervision or support and collaboration with policy and practice partners
3. access to required resources, including expertise.

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]*

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## Budget details

Provide budget details for the Activity across future years in the table below.

The total budget must be no more than $1,000,000 ex GST over a maximum of 42 months.

Please note the following with regards to salary costs:

* *Salary level and industry award and agreements should be listed for each position (including whether it is a new or existing and recruited to or requires recruitment). Salary levels should be confirmed by a relevant officer such as a Business Manager. The timeframe required for creation and filling of positions should be factored into the ‘Milestones’ table of the Application Form.*
* *Salary on-costs are claimable up to 30% (i.e. payroll tax, superannuation, leave loading, workers’ compensation, and insurance payments) however must be identified and justified.*
* *WA public health system applicants must claim salary on-costs in accordance with the WA Health* [*Financial Management Manual*](https://healthpoint.hdwa.health.wa.gov.au/FinanceGroup/Chapter%205%20Revenue%20Management/FMM%20s521%20-%20On-Cost%20Charges%20v0-60.pdf) *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.*
* *Major equipment items will not be funded. Minor equipment items considered essential to the Activity will be funded (up to $10,000 and quotations must be provided). Any equipment purchased becomes the property of the Responsible Entity.*
* *Requests for travel funds will not be approved unless the travel is specifically required to undertake the Activity or is directly related to Activity outcomes.*
* *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 (the OMRI is an exempt organisation).*

Where applicable, other sources of funding and in-kind support should be included in the budget.

Costs must be verified by the Responsible Entity’s Finance Officer or Business Manager as per Section 23 of the Application Form.

| **BUDGET ITEM** | **ACTIVITY FUNDING REQUEST**  **($ EX GST)** | | | | | **ACTIVITY SUPPORT**  **($ EX GST)** | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity costs** | **Year 1** | **Year 2** | **Year 3** | **Year 4**  **(6 months only)** | **TOTAL** | **ADDITIONAL IN-KIND SUPPORT** | **ADDITIONAL CASH CONTRIBUTION** | **TOTAL** |
| **Personnel**  *specify for each position*  **Position 1**   * *title* * *new/ existing* * *%FTE* * *salary and on-costs*   Position 2   * *title* * *new/ existing* * *%FTE* * *salary and on-costs* |  |  |  |  |  |  |  |  |
| **Minor essential equipment**  *maximum $10,000*  *quotations must be attached* |  |  |  |  |  |  |  |  |
| **Consumables** |  |  |  |  |  |  |  |  |
| **Consumer Involvement**  *e.g., honoraria payments etc.* |  |  |  |  |  |  |  |  |
| **Other**  *specify each item* |  |  |  |  |  |  |  |  |
| **Other items** | **Year 1** | **Year 2** | **Year 3** | **Year 4**  **(6 months only)** | **TOTAL** | **ADDITIONAL IN-KIND SUPPORT** | **ADDITIONAL CASH CONTRIBUTION** | **TOTAL** |
| **Overhead costs**  *maximum of 10%* |  |  |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |  |  |

## 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 (if existing 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 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 this expenditure is not in WA explain why this is necessary.

*[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 funding already secured, 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, unless an alternative arrangement is agreed between the Activity Lead and OMRI.

### 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 and 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 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** |  |
| **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** |  |

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

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