# Request for Proposal Application - Practice Manager Champion

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| **PROVIDER DETAILS** |
| Legal Entity Name: |  |
| Registered Trading Name (if applicable): |  |
| ABN (or ACN if appropriate): |  |
| Registered Address: |  |
| Postal Address: |  |
| Phone: |  | Website: |  |
| Email: |  |

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| **PARTNER/CONSORTIUM DETAILS (IF APPLICABLE)**  |

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| Legal Entity Name: |  |
| ABN (or ACN if appropriate): |  |

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| **CONTACT DETAILS** |
| **Principal Contact:** This is the person who is legally authorised to enter into contracts on behalf of your organisation |
| Contact Name: |  |
| Position: |  |
| Email: |  |
| Phone: |  |
| **Contact for this Application (if different from above)** |
| Contact Name: |  |
| Position: |  |
| Email: |  |
| Phone: |  |

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| **CONFLICTS OF INTEREST** |
| Do you or any of your organisation’s personnel for example employees, contractors, board members or their immediate family members have a personal or business relationship with NT PHN or any of our staff?*(Please note that declaring a conflict will not impact on the assessment of your application. However, knowing this information will enable NT PHN to manage the situation appropriately).* | [ ]  Yes - provide details below[ ]  No |

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| **APPLICATION QUESTIONS** |
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| Please provide insight into the merit you possess to be a Practice Manager champion. For example, experience, education and/or transferrable skills relevant for the activity such as experience developing resources, mentoring others and undertaking education to a broad range of providers.(300 words or less preferred) |  |
| Please provide details to your ability and commitment to a quick turnaround time for ad hoc requests and to coordinate appropriate timeframes for delivery of other types of support e.g. resources and education. Include approximate timeframes e.g. response within # of business days.(300 words or less preferred) |  |
| Can you provide a description of how you would provide support and mentorship across NT PHN staff, Practice Managers and other NT PHN networks; as well as hands-on delivery of education and development of resources?Please Include information around quality assurance and sustainability.(300 words or less preferred) |  |
| If you are unable to undertake this role for various reasons, what strategies could you put in place to avoid service delivery issues?(300 words or less preferred) |  |
| Please describe your ability and expertise to provide support across the following areas: * Practice accreditation
* Medicare Benefits Schedule (MBS)
* Practice Incentive Program
* Quality Improvement
* Practice staff training priorities
* Practice Manager Networking
* Disaster Management Plans

(300 words or less preferred) |  |
| When are you able to commence the service? | Click or tap to enter a date. |
| Are you willing to travel within the Northern Territory required? | [ ]  Yes [ ]  No |
| Please attach evidence of expertise in practice management e.g. Curriculum Vitae for individuals or profile details of staff supporting the activity for organisations(This is a requirement to assess your application) | [ ]  Yes - attached [ ]  No |

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| COST |  |
| Please provide a detailed quotation / schedule of rates, listing all expenditure directly related to the activity. All figures must be GST exclusive. |
| Hourly rate | $ |
| Other fees and rates: add other rows with details as required | $ |
| Total cost (excluding GST) | $ |

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| **REFERENCE 1** |
| Details of one Australian based referee who can comment on your expertise to deliver this scope of work and working with you as a client. | Name: |  |
| Position: |  |
| Organisation: |  |
| Phone: |  |
| Email: |  |

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| **REFERENCE 2** |
| Details of one Australian based referee who can comment on your expertise to deliver this scope of work and working with you as a client. | Name: |  |
| Position: |  |
| Organisation: |  |
| Phone: |  |
| Email: |  |

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| **DECLARATION** |
| **This section must be completed by an authorised representative of the organisation:**I declare on behalf of Choose an item. that:1. The contents of this application are to the best of my knowledge accurate, complete and do not contain any false, misleading or deceptive misrepresentation, claims or statements
2. I confirm we meet all the eligibility requirements
3. I agree to contact NT PHN should I become aware of any changes to information contained in this application
4. I agree to declare as part of the application process any actual, perceived or potential conflicts of interest, for example financial, material or professional.
5. I understand that this application does not create a legal or binding commitment, arrangement or understanding between NT PHN and the applicant organisation.
6. I am authorised to make this declaration on behalf of the applicant/s.

Please submit yes if you agree this is a true declaration: Yes [ ]  No [ ]

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| Name (Block Letters): |  |
| Position of Authorised representative: |  |
| On behalf of (Organisation): |  |
| Date: |  |

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