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