**GP Innovation (GPI) Initiative**

**Application Form**

*Please ensure that this form is filled up completely with accompanying proposal covering all sections outlined in the* ***Project Proposal*** *section below. Where information is not available or applicable, please indicate accordingly. Please enclose the detailed proposal and all supporting documents as addendum to this form. We encourage you to read the GPI Initiative Guidelines and FAQs before completing this.*

1. **GENERAL INFORMATION OF THE APPLICANT/S**

|  |  |  |  |
| --- | --- | --- | --- |
| Lead General Practitioner (GP) and Clinic Name |  | | |
| Lead GP Clinic  Correspondence Address |  | | |
| Tel No. |  | Fax No. |  |
| Lead GP/ Project Manager Details | Name: | | |
| Email Address: | | |
| Contact No: | | |
| GP Name  Clinic Name and License No.  (At least five (5) GP clinics in the partnership; please add rows if you have more GP Clinics) | |  |  |  | | --- | --- | --- | | Name of GP | Clinic Name | Clinic License No. | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | |
| Primary Care Network (PCN) Name  (For application involving more than 1 PCN, please indicate all) |  | | |

1. **PROJECT DETAILS**

|  |  |
| --- | --- |
| Project Title |  |
| Project Start Date |  |
| Project End Date |  |
| Project Summary (Up to 100 words) |  |

**Project Proposal (***To be attached separately, covering the following areas where applicable. Please refer to the GPI Initiative document)*

1. **About your Project**

* Reason for the need for the project to address the ‘Challenge statement’
* Project idea and scope
* Partnerships between GPs within the PCN (please highlight how you will work together with other GPs in this partnership. Please indicate any other partnerships, if applicable)

1. **Project Outcomes and Impact**

* Description of how the project meets the GPI Initiative’s outcomes
* Quantitative benefits/indicators (please include quantitative benefits, such as, increase in number of chronic patients, development of new business model/s and cost efficiencies)
* Qualitative benefits/indicators (please outline the qualitative benefits arising from the implementation of the project, for example, improved health outcomes and clinical indicators, new care redesign models)

**(Please set targets for both the Quantitative and Qualitative Indicators)**

1. **Project Implementation**

* Implementation methodology (please outline the project’s approach, activities and alignment with key stakeholders)
* Implementation schedule (please provide schedule of the project activities, timeline and the key milestones)
* Plan to scale the project within your PCN and the timeline for scaling

1. **Target beneficiaries**

* Description of the target chronic diseases patient group

1. **Budget Summary**

* Summary of project costs and detailed cost breakdown (Refer to Annex)
* Project financing milestones

1. **Management and Project Team**

* Please outline the organisation of the team working on this project, including the positions, roles and responsibilities of the people working on this project.
* Please highlight if a Project Manager will be appointed to oversee the Partnership.

1. **Other Grant applications for this Project/ Collaborations with Other Government Agencies (if any)**

* Please declare if you are concurrently applying for any government grant for this Project. If yes, please provide details:
  + Name of Government Agency and Programme(s)
  + Date applied/awarded
  + Start and end date of grant (If applicable)
  + Grant quantum awarded/applied
  + Please also indicate if there are any specific activities/components related to this project, where grant has been awarded/applied

1. **Project Evaluation**

* Please confirm that you are agreeable to work with MOH Office for Healthcare Transformation (MOHT) and Ministry of Health (MOH) Primary and Community Care Division (PCCD) for developing the evaluation framework and monitoring of this project, including clinical indicators for health outcomes, patient adherence to GP visits, patient satisfaction and costs should the proposal be selected.

1. **ENGAGEMENT WITH MOHT**

MOHT would like to engage the project teams at least quarterly in year one and at least on a half-yearly basis after one year to co-learn and enable the progress of the project to reach intended outcomes as far as possible. Please confirm that you are agreeable to work with MOH Office for Healthcare Transformation (MOHT) on such basis should the proposal be selected.

1. **DECLARATION**

I/We declare that:

1. The applicant/s has/have not applied for any other form of government financial support for the cost to be supported under this project apart from the GP Innovation Initiative from MOHT.
2. The facts stated in this application and the accompanying information are true and correct to the best of my knowledge and that I/We have not withheld/ distorted any material facts. I/We understand that if I/We obtain the grant by false or misleading statements, it may be subject to the relevant legislation, in addition, MOHT may, at its discretion, withdraw the grant and recover immediately from the applicant/s any amount of the grant that may have been disbursed.
3. The applicant/s is/are aware that MOHT may seek inputs from the its Advisory group and/or Board as part of project evaluation and the applicant/s may be required to prepare and present information that will be shared with MOHT’ Advisory group and/or its Board.

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| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Lead GP** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Full Name & Name of Clinic** |  |  |

**Participating GP Clinics (corresponding to Section 1)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No** | **Name of GP** | **Name of Clinic** | **Signature of GP** | **Date** |
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**PCN Headquarters Leads (corresponding to Section 1)**

**Supported by:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No** | **Name of PCN Lead (indicate Clinical or Admin)** | **Name of PCN** | **Signature of PCN Lead** | **Date** |
|  |  |  |  |  |
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| --- | --- |
|  | AnnexSummary of Project Budget |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Cost Components** | | **($)** | |
|  | **Manpower-related Costs (Supernumerary staff)** | | $ | |
|  |  | Salary  Salary | | $ | |
|  |  | Training | | $ | |
|  | **Equipment, Software, Materials & Consumables** | | $ | |
|  |  | Equipment | | $ | |
|  |  | Software | | $ | |
|  |  | Materials & Consumables | | $ | |
|  | **Project set up Costs**  **)** | | $ | |
|  | **Other Costs** (please specify) | | $       $ | |
|  | **Total** | | $ | |

Please specify the payment schedule that is needed on a quarterly basis for this project.