Grant Applications

Notification of Intention to Apply

Applicants must submit this form before applying for a grant when a CALHN employee is named as an investigator or CALHN is committing resources (e.g. staff time, consumables, services, patient recruitment & collection of data/samples). Outside of exceptional circumstances, if an EOI is not received **two weeks before** the grant submission deadline, **applications will not be supported.**

Please direct any enquiries and email the completed form to CALHN Research Services at [Health.CALHNResearchGrants@sa.gov.au](mailto:Health.CALHNResearchGrants@sa.gov.au).

**A. Grant Proposal**

1. **Project Identification and Summary**

|  |  |  |
| --- | --- | --- |
| **Application ID / Reference Number** | |  |
| **Project Title** |  | |
| **Brief Lay Summary** *(max 100 words)* | | |
| **Expected benefits to CALHN in the purview of patient care and health service improvements.** *(max 100 words)* | | |

1. **Grant Initiative and Proposed Submission Date**

|  |  |  |
| --- | --- | --- |
| **Granting agency:** Choose an item. | | **Resubmission** |
| **Submission due date:** Click to enter a date. | | **Minimum data due date** (if applicable)**:** Click to enter a date. |
| **Initiative/Grant Scheme:** Click here to enter text. | | |
| **App Type:**  **Project**  **Fellowship**  **Travel**  **Equipment**  **Other:** *Specify* | | |
| **Duration of Grant:** |  | |
| **Total Value of the Grant:** | **$** Click here to enter text. | |
| **Proposed $ allocated to CALHN:** | **$** Click here to enter text. | |
| ***If CALHN allocation is $0, provide justification:*** | Click here to provide justification. | |
| **Proposed use of the grant funding to CALHN:** | Salaries & Wages  Medical, Surgical & Laboratory Supplies/ Consumables  Equipment  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Contribution/s of the University/Institute:** *What is the contribution of the University/Institute?* | | |

1. **Chief Investigators**

**(a) Lead Investigator**

|  |  |  |
| --- | --- | --- |
| **Chief Investigator A** | | |
| **Name**  Click here to enter text. | **Organisation Employed By**  Click here to enter text. | **Email**  Click here to enter text. |
| *If CIA is employed by CALHN:* | | |
| **TQEH/RAH/Hampstead** | **SA Pathology** | **Other** Click here to Specify. |

|  |  |
| --- | --- |
| **Administering Institution** *(for this application)*  Click here to enter text. | **Email**  Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CALHN Primary Site of Research** | | | | |
| **TQEH** | **RAH** | **Hampstead** | **SA Pathology** | **Other** (specify below) |
| Click here to Specify actual CALHN site(s) (ie BHI, Frome Road). | | | | |

**(b) Named CALHN Investigators** (Please add rows as required)

**All research conducted with and in CALHN must have CALHN CI listed in your application.**

**CALHN Investigator (CI and AI) must list ‘Central Adelaide Local Health Network Incorporated’ as their Primary Institution as this is the legal entity.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Investigator’s Name** | **\*FT/PT/**  **PT-O/CA** | **Position** | **CALHN Program: Dept : Unit** | **Email** |
|  |  |  | Choose Program: Dept: Unit. |  |
|  |  |  | Choose Program: Dept: Unit. |  |
|  |  |  | Choose Program: Dept: Unit. |  |

**\*FT = Full time, PT = Part time, PT-O = Part-time, outside CALHN capacity, CA = Clinical Academics**

**For Part-time CALHN employees and Clinical Academics who will be acting outside their CALHN capacity (PT-O), kindly provide an email confirmation from your Medical Lead. The email should include the**:

* project details (i.e., title, CIA, project description, administering institution),
* your role/what you will be doing in your other capacity and primary site where this will be conducted
* confirmation that you will not do anything in your CALHN-capacity.

**B. CALHN Involvement and Contributions**

1. **CALHN Involvement and Contributions**

|  |  |
| --- | --- |
| **Role of CALHN**  **If applicable (i.e. Sapphire applications),** please indicate **‘Central Adelaide Local Health Network Incorporated’** on the application as the Partner Organisation/Participating Institution as this is the legal entity. | **Partner Organisation**  **Participating Institution** |
| **Is a Letter of Support required by the funding body?**  If yes, ensure that you provide a draft of the letter of support following the guidelines of the funding round. Include the in-kind contribution expected from CALHN. This letter will be reviewed by the CALHN RSO, who will arrange signing with the appropriate CALHN delegate*.* | **Yes**  **No** |
| **Do you require Facility Letters?** | **Yes**  **No** |
| **What is CALHN contributing?**  Please detail CALHN’s contributions to the study, and include staffing impact, ethics & governance, data access, patient recruitment, other service provisions (i.e., facility and IT use), consumables. | |
| **If CALHN is providing in-kind contributions, kindly specify the monetary equivalent for the duration**.  *Please provide a justification on why the in-kind contributions are not funded by the project/grant.* | |

***In-kind salary provided by CALHN (Please add rows as required)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Position** | **FTE** | **Estimated $ Value**  **per year** | **Number of Years/Duration** | **TOTAL** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **TOTAL** | |  |  |  |

*Non-salary In-kind support (e.g. Ethics & Governance, Data, IT, equipment, facility use, services, consumables)*

*provided by CALHN (Please add rows as required)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Estimated $ Value**  **per year** | **Number of Years/Duration** | **TOTAL** |
|  |  |  |  |
|  |  |  |  |
| **TOTAL** |  |  |  |

1. **Digital Health Requirements.** Does the project require any of the following?  **Yes  No**

If yes, please tick as required:

|  |  |  |
| --- | --- | --- |
| the purchase or use of software within CALHN that requires server infrastructure | a product acquisition | Digital health security review |
| ICT solutions/development | CALHN Digital Health data extraction or | Interactions with any SA Health Digital platforms? |
| Other/s: Specify Click here to enter text. | | |

1. **Procurement of Goods and Services.** Please reach out to [Health.CALHNProcurement@sa.gov.au](mailto:Health.CALHNProcurement@sa.gov.au) for further

Information.

|  |  |
| --- | --- |
| **Equipment to be purchased/scope of services:** |  |
| **Estimated Value (in AUD$):** |  |
| **Other associated costs**  **(e.g., maintenance, subscription):** |  |
| **Expected duration of use:** |  |

1. **Please check that you attach a copy of the following:**

Completed NIA form

Endorsements from the Clinical Program Director AND Medical Lead/Head of Unit *(please see next page)*

Application Documents: Application Form, Profile Report, Application Report, Application Summary and Application

Proposal *(should include a list of all CI’s and budget details)*

Draft Letter of Support (if required)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **C. Certification and CALHN Endorsement**  Before the application is submitted, CALHN Investigators must provide CALHN RSO written evidence of endorsement and/or support to undertake the project should it be successful, within their Program/Department from the Clinical Program Director AND Medical/Allied Health/Nursing Lead/Head of Department. CALHN Investigators are responsible for reaching out to their Clinical Program Directors and Medical/Allied Health/Nursing Leads/Heads of Department  CALHN Institutional endorsement will not be granted and provided to the Administering Institution until all requested items have been received by the CALHN RSO Grants Team.  **1. Certification by the CALHN Chief Investigator(s)**  I accept responsibility for the performance of the study in compliance with all occupational health safety and welfare and regulatory requirements governing the use of the facilities utilised.  I will provide a revised budget to my Head of Unit, Medical Lead and Clinical Program Director if the application is successful but receives less than the funding requested.  I have discussed the research with the Clinical Program Director and Medical Lead whose areas will be involved in any way in the project (including the other investigators) to ensure they are aware of what is involved and approve the project being undertaken.   |  |  |  |  | | --- | --- | --- | --- | | Title / First name /Surname | Choose Program: Dept: Unit. | ***Date*** | ***Signature*** |  1. **Endorsement by the Medical/Nursing/Allied Health Lead/Head of the Department AND Clinical Program Director (email endorsements are acceptable)**   Where the CALHN Investigator is also the medical/nursing/allied health lead, clinical program director, or equivalent, certification must be sought from the person to whom the head of department is responsible. **Investigators cannot endorse their own research.**  I certify that:   1. I have read the referenced project application and I have discussed this project and the resource implications with the principal investigator. 2. The principal investigator and other investigators involved in the project have the necessary skills, training, and experience to undertake their role, and where necessary, appropriate training and supervision has been arranged. 3. There are suitable and adequate facilities and resources in the Unit for the project to be conducted and they are available for the duration of the project if the applicant is successful. 4. The research project has been costed appropriately and there are sufficient funds to cover the costs of conducting research. 5. I am prepared to have the research carried out strictly in accordance with the funding source’s conditions governing the Research Grant at the time.  |  |  |  |  | | --- | --- | --- | --- | | **HEAD OF DEPARTMENT** | Title / First name /Surname | ***Signature*** | ***Date*** | | **Choose Program: Dept: Unit.** | | **MEDICAL/NURSING/**  **ALLIED HEALTH LEAD** | **Choose an item.** | ***Signature*** | ***Date*** | |  | | **CLINICAL PROGRAM DIRECTOR** | **Choose an item.** | ***Signature*** | ***Date*** |  |  |  |  |  | | --- | --- | --- | --- | | ***SA PATHOLOGY (delete if not applicable)*** | | | | | **Prof Joy Rathjen** | **Director, Research and Innovation** | ***Signature*** | ***Date*** | |