Cybersecurity Uplift SMB1001 Program EOI
Form Preview

Eligibility

* indicates a required field

Applicants: please note

Before completing this application form, it is important that you have read the EOI guidelines: Guidelines.

Incomplete applications and/or applications received after the closing date will not be considered.

This section of the application form is designed to help you, and us, understand if you are eligible for this grant. Please complete these questions honestly to ensure you are not applying for an unsuitable grant.

If you have any questions in relation to the eligibility criteria, please contact grants@thephn.com.au

Confirmation of Eligibility

The Cybersecurity Uplift to SMB1001 Tier 2 alignment reduces risk but cannot prevent every cyberattack or eliminate all cybersecurity risks. The Practice remains responsible for maintaining implemented controls, managing service providers and addressing ongoing risks after the program.

The aim is to provide education and resources that will uplift cybersecurity maturity, reduce third-party risk exposure, and ensure alignment with national privacy obligations. The onus remains on the Practice to ensure the implementation and ongoing management of their own security controls.

I confirm that the applicant ...

- has read and understands the guidelines and requirements
- is committed to improving cybersecurity and is willing to contribute the time, resources and expenditure **(Practice costs)** on suggested technology improvements as identified through the program
- is a located in (and/or supplies services to) **Hunter New England/Central Coast region**
- has no outstanding reports or money to **HNECC PHN** as a result of previous funding or grants
- has the appropriate type and level of insurance for the activities that are the subject of this grant
- understands that a co-payment of $200 ex GST will be required if successful, payable to the consultant.

Please select below: *

○ Yes ○ No

You must confirm that all statements above are true and correct.

If successful, I confirm that I have or will have Microsoft 365 Business Premium in place before technical work begins. *
○ Yes
○ No
This is a mandatory requirement of the grant

Do you have a conflict of interest to declare? This includes any relationship with PHN Board, PHN committees, or any parties associated with this grant opportunity. *
○ Yes ○ No

If yes, please outline the conflict. You can continue to complete the application form. The conflict will be reviewed as part of the assessment process. *

Organisation/Contact Details

* indicates a required field

Privacy Notice

We pledge to respect and uphold your rights to privacy protection under the Australian Privacy Principles (APPs) as established under the *Privacy Act 1988* and amended by the *Privacy Amendment (Enhancing Privacy Protection) Act 2012.* To view our privacy statement, go to **PHN Privacy Policy**.

Please select if you would not like to be notified about forthcoming grant opportunities.
○ I do not want to be notified about future grant opportunities

Applicant Details

Allied Health or General Practice Name *
Organisation Name

Practice Main Address (within the HNECC PHN region)
Address

Practice main phone number *
Must be an Australian phone number.

Practice email address *

Must be an email address.

Applicant ABN *

The ABN provided will be used to look up the following information. Click Lookup above to check that you have entered the ABN correctly.

Information from the Australian Business Register	
ABN	
Entity Name	
ABN Status	
Entity Type	
Goods & Services Tax (GST)	
DGR Endorsed	
ATO Charity Type	More information
ACNC Registration	
Tax Concessions	
Main Business Location	

What are the main services your organisation provides? *

☐ General Practice
☐ Urgent Care Clinic
☐ Skin Cancer Clinic
☐ Telehealth
☐ Dietitians
☐ Exercise Physiologists
☐ Occupational Therapists
☐ Physiotherapists
☐ Podiatrists
☐ Speech Pathologists
☐ Social Workers
☐ Psychologist
☐ Other:

Please choose all that apply.

How many clinicians are employed in your practice? (including contractors and consultants) *

○ Solo - 1
○ Small - 2 to 5
○ Medium - 6 to 15
○ Large - 16 or more

Total number of staff (including employees, consultants and contractors) *

Must be a number.

Primary Contact Details

Primary contact (person who will undertake the cybersecurity framework implementation) *

Title | First Name | Last Name

This is the person we will correspond with about this grant.

Position held in organisation *

Primary contact phone number *

Must be an Australian phone number.

Primary contact email address *

This is the address we will use to correspond with you about this grant.

Explain your current role in the organisation. Describe how you are empowered to make digital security changes for the better within your organisation? *

Applicant Capacity

* indicates a required field

In the last 12 months have you taken action to improve your practices digital capability? Explain how. *

Word count:
Must be no more than 250 words.

Please indicate the availability and usage of the following digital applications within your practice.

My Health Record *

Practice Website *

Secure Messaging *

Telehealth *

Clinical Practice System *

Online Patient Bookings *

Current Systems

A mandatory requirement is that the Practice is using Microsoft 365 Business Premium. What is your current status: *

- ○ Currently use Microsoft 365 Business Premium
- ○ Currently use Microsoft 365 product and willing to upgrade
- ○ Do not use Microsoft 365 but willing to change
- ○ Other:

Are your IT and technology requirements managed by an external company? *

- ○ Yes
- ○ No
- ○ Not sure

If so, the Practice must ensure that they allow access to and will work with the PHN consultant. Please list the company below.

Cybersecurity

Please rate the following where:

1 is the lowest level

2 is a lower than average level

3 is an average level

4 is a moderately high level

5 is the highest level.

How would you rate your understanding of cybersecurity measures? *

Must be a number.

Number is between 1 and 5

How cybersecure is the practice at present? *

Must be a number.
Number is between 1 and 5

How secure is your patient data (including adherence to privacy regulations)? *

Must be a number.
Number is between 1 and 5

How would this opportunity assist your practice? *

Would you like to provide any further information to support this application? *

Certification and Feedback

* indicates a required field

Certification

This section must be completed by an appropriately authorised person on behalf of the applicant organisation (may be different to the contact person listed earlier in this application form).

I certify that to the best of my knowledge the statements made within this application are true and correct, and I understand that if the applicant organisation is approved for this grant, we will be required to accept the terms and conditions of the grant as outlined in the letter of agreement (contract) and guidelines.

I agree * ○ Yes ○ No

Please read and acknowledge the following requirements:

- I am the owner/ manager or the owner/manager supports me to undertake this opportunity of behalf of our practice.
- I understand the Practice is responsible for costs and resources associated with the project

and implementation of agreed digital security improvements

- I understand the PHN is responsible to providing guidance, professional support and digital security uplift opportunities during the project period.
- I understand that places are limited, and should I be offered a place, I will endeavor to participate in all relevant meetings and associated implementation activities including regular and connected communication about my availability.
- I understand that the initiative is delivered over a period of months and hours (refer to EOI guidelines for further details).
- I will pro-actively engage with the program and provide constructive feedback throughout the process.
- I will participate in pre and post evaluation of this program.
- I understand de-identified information on the practice's business knowledge may be shared.

I have read and agree * ○ Yes ○ No

If successful, I give permission for the PHN to provide the project contact's details to the third party consultant to facilitate this program. * ○ Yes ○ No

Name of authorised person *

Title | First Name | Last Name

Position *

Position held in applicant organisation

Contact phone number *

Must be an Australian phone number.
We may contact you to verify that this application is authorised by the applicant organisation

Contact Email *

Must be an email address.

Date *

Must be a date

Applicant Feedback

You are nearing the end of the application process. Before you review your application and click the **SUBMIT** button please take a few moments to provide some feedback..

Please indicate how you found the online application process:

○ Very easy ○ Easy ○ Neutral ○ Difficult ○ Very difficult

How many minutes in total did it take you to complete this application?

Estimate in minutes i.e. 1 hour = 60

Please provide us with your suggestions about any improvements and/or additions to the application process/form that you think we need to consider.

Word count:

Must be no more than 250 words.