Application Form (Form A)

For applications to be valid, all details need to be completed and declarations signed and dated.

Eligible applicant to complete this section

|  |  |  |  |
| --- | --- | --- | --- |
| Please indicate whether this is a: | New Application | or | Renewal Application |

# Applicant Details

|  |  |  |
| --- | --- | --- |
| Name of Approved Community Pharmacy/ Approved Hospital Authority: | Name of Approved Pharmacist/ Approved Hospital Authority Contact | |
|  |  | |
| Eligible Applicant PBS Approval Number: | ABN: | |
|  |  | |
| Address: |  | |
| Physical address | | |
| Suburb | State | Postcode |
| Postal Address: |  | |
| Postal address | | |
| Suburb | State | Postcode |

## Declaration

I confirm that:

* I am providing the Section 100 Support Services to the approved Remote Area Aboriginal Health Service (AHS) named below, as per the approved Program Rules and via arrangements made under Section 100 of the *National* *Health Act 1953*.
* The nominated Aboriginal Health Service has provided appropriate advice on local Aboriginal and Torres Strait Islander Community arrangements and health issues
* I have undertaken appropriate Aboriginal and Torres Strait Islander people cultural orientation using the resources contained on the PPA Website S100 Pharmacy Support Allowance page.

I declare that the information given by me in this application is true and correct.

|  |  |
| --- | --- |
| Signature of Approved Pharmacist/Approved Hospital Authority contact: | ****Date**** |
|  |  |

# Aboriginal Health Service

Chief Executive Officer or Medical Director of Aboriginal Health Service to complete this section

|  |  |  |
| --- | --- | --- |
| AHS Name: | | |
|  | | |
| Address: | | |
| Physical address | | |
| Suburb | State | Postcode |

If more than one Outstation is being serviced, please copy and paste the details below for each.

|  |  |  |
| --- | --- | --- |
| Outstation: | | |
|  | | |
| Address: | | |
| Physical address | | |
| Suburb | State | Postcode |

Please provide details of any Outstations of this Aboriginal Health Service to which the named Eligible Applicant is providing support services on the attached Distance Details form.

|  |  |
| --- | --- |
| S100 Approval Number: | Commencement Date (current reporting cycle):  The agreed date with the above Eligible Applicant to start Section 100 Support Services |
|  |  |

## Declaration

I declare that:

* This Aboriginal Health Service has entered into an agreement with the named Eligible Applicant for the provision of services to support supply arrangements made under Section 100 of the *National Health Act 1953*;
* An agreed Work Plan for Quality Use of Medicines (QUM) Support Services to be provided over the next 12 months has been developed between the named Eligible Applicant and this Aboriginal Health Services
* The named Eligible Applicant has been advised on local Aboriginal and Torres Strait Islander Community arrangements and health issues.

|  |  |
| --- | --- |
| Signature: |  |
|  | |
| Full Name: | Date: |
|  |  |

# Application for Section 100 Support Allowance

## Distance Details

Please use a separate form for each AHS.

|  |  |  |  |
| --- | --- | --- | --- |
| Primary AHS name/S100 Approval Number and Outstation(s) | Round trip distance between the AHS and the Pharmacy or Hospital Authority | Is the AHS on an island? (Y/N) | Usual mode of travel (e.g. car, boat, aircraft) |
|  | km |  |  |

### Outstation

For the purpose of this Allowance, an Outstation is defined as a remote, permanent Health Service of the primary Aboriginal Health Service, where prescription (‘Schedule Four’) medicines are stored in compliance with an approval issued by the relevant state/territory Health Authority, and is staffed by at least one permanent Health Care Worker.

|  |  |  |  |
| --- | --- | --- | --- |
| Outstation(s) | Round trip distance between the Outstation(s) and the Pharmacy or Hospital Authority | Is the Outstation(s) on an island? (Y/N) | Usual mode of travel (e.g. car, boat, aircraft) |
|  | km |  |  |
|  | km |  |  |
|  | km |  |  |
|  | km |  |  |
|  | km |  |  |
|  | km |  |  |
|  | km |  |  |

## Declaration

I declare that the Aboriginal Health Service and Outstation information provided on this form is true and correct.

|  |  |  |
| --- | --- | --- |
| Eligible Applicant Name: |  | CEO/Medical Director name**:** |
|  |  |  |
| Signature of the Approved Pharmacist/ Approved Hospital Authority contact: |  | Signature of CEO/Medical Director: |
|  |  |  |
| Date: |  | Date: |
|  |  |  |

|  |  |
| --- | --- |
| This program is funded by the Australian Government Department of Health as part of the Seventh Community Pharmacy Agreement. | |
|  | CONTACT THE SUPPORT CENTRE: 1800 951 285 | support@ppaonline.com.au |