Pharmacy Programs Administrator

PROGRAM DECLARATION FORM

Indigenous Health Services Pharmacy Support (IHSPS) Program

July 2021

INTRODUCTION

This form is only to be used by Indigenous Health Services, both ACCHOs and State-run IHSs, who have **not** delegated authority to a Service Provider and intend to participate in the Indigenous Health Services Pharmacy Support (IHSPS) Program as defined by the IHSPS Program Rules.

By completing this form, you will agree to the Program Rules as accepted by all Program Participants. The information you provide in this form will also allow the Pharmacy Programs Administrator (PPA) to register your organisation on the PPA Portal and upload documentation to the PPA Portal on your behalf in order to make payments to your nominated account.

Please complete the form and read the declaration carefully before signing and submitting to the relevant email address for your IHS type as detailed below.

NEXT STEPS

State-run IHS

If you require assistance please contact the PPA at **support@ppaonline.com.au**

When you have completed this form, please submit alongside your Work Plan to the **PPA Inbox** at **IHSPS@ppaonline.com.au**

Please make sure you submit the Program Declaration Form and Work Plan by **11:59pm (AEST) on 15 October 2021**

ACCHO

If you require assistance with your Work Plan please contact NACCHO at **qum@naccho.org.au**

If you require assistance with this Declaration Form please contact the PPA at **support@ppaonline.com.au**

When you have completed this form, please submit alongside your Work Plan to **NACCHO** at **qum@naccho.org.au**

Please make sure you submit the Program Declaration Form and Work Plan by **11:59pm (AEST) on 15 October 2021**

ORGANISATION DETAILS

This form must be submitted alongside the Annual Work Plan by **15 October 2021**, late submissions will not be accepted.

Indigenous Health Service (IHS) Details											
IHS Name											
IHS ABN											
Physical Address											
	City/Town				**State**			**Postcode**			
Postal Address *If different from above*											
	City/Town				**State**			**Postcode**			
IHS Type *ACCHO or State/Territory-run IHS*	<Please select from drop-down list>										
Approved RAAHS? *If 'Yes', please provide RAAHS ID#*	☐ Yes, provide RAAHS ID# ☐ No				**RAAHS ID#**						

Bank Details	
Account Name	
BSB	
Account Number	

Chief Executive Officer (CEO) Details	
Name	
Email	

Finance Contact Email *(for remittance advice to be sent to)*	
Email	

*Whether you are a Remote or Non-remote Indigenous Health Service was determined as part of your approval to participate in the Section 100 Remote Area Aboriginal Health Services (RAAHS) Program.

DECLARATION

I, the Chief Executive Officer of the Indigenous Health Service named in this form, confirm that I am authorised to bind the organisation and confirm that we will abide by the the Program Rules and the Pharmacy Programs Administrator (PPA) General Terms and Conditions. In addition, I confirm that funds will only be used for the purposes set out in approved Work Plans.

By signing, I declare that:

- The information provided is current and correct
- The Service currently meets and will continue to meet, eligibility criteria as per the IHSPS Program Rules while participating in the Program
- The Service will advise the Pharmacy Programs Administrator if it ceases to be eligible for the Program
- The Service agrees to meet all requirements as set out in the Pharmacy Programs Administrator General Terms and Conditions and IHSPS Program Rules
- I agree that a Pharmacy Programs Administrator Operator will create a PPA Portal account and submitted approved Work Plans and Progress Reports into the PPA Portal on the Service's behalf in order to make payments to the Service's nominated bank account
- In the event the bank details of the Service change, the new account details will immediately be provided to the Pharmacy Programs Administrator so that they can update the Service's account details in the PPA Portal
- The Pharmacy Programs Administrator will not be held responsible if payments are made to the incorrect bank account due to incorrect bank details being provided in this Declaration Form or the Service not providing updated details where there has been a bank account change. I also acknowledge that where payments have been made to an incorrect bank account due to the above, remedial payments cannot be made to the correct bank account until such time as the original funds have been recovered and repaid to the Pharmacy Programs Administrator
- The Service agrees to allow the issue of Recipient Created Tax Invoices as outlined in GSTR 2000/10
- I acknowledge that the Service is registered for GST and that it will notify the recipient (the PPA) if it ceases to be registered.

Providing false or misleading information is a serious offence and auditing of deliverables submitted under the IHSPS Program, including supporting evidence, may occur. All records should therefore be maintained in accordance with the Program Rules.

Signed		**Date**	
Print Name			