LEVEL 2

APPLICATION FORM

£12,000 available for a project lasting up to 12 months

Applicant organisation name

Applications must be completed using Adobe Acrobat or Reader only

Funded by

Department of Health
www.health-ni.gov.uk

Community Development & Health Network

PART 1: Partner information

1.1a Community Partner details	
Name:	
Position:	
Organisation:	
Organisation address:	
Town/City:	Postcode:
Contact mobile:	Contact landline:
Contact email:	
Organisation landline:	
Organisation email:	
Twitter:	Facebook

1.1b Pharmacy Partner details	
Name:	
Position:	
Pharmacy name:	
Pharmacy address:	
Town/City:	Postcode:
Contact mobile:	Contact landline:
Contact email:	
Pharmacy landline:	
Pharmacy email:	
Twitter:	Facebook:

1.1c Who will be the lead partner for your project? Please mark X box only.			
	Community Partner		Pharmacy Partner

1.2a	**Is the community partner a constituted group?** **We only fund constituted groups.** **Please attach a copy of your constitution to the email.**		Yes		No	
1.2b	**Does the pharmacy partner hold a current community pharmacy contract?**	Pharmacy Number	Yes		No	

1.3 If you are a community/ voluntary organisation, please give us a brief history of your organisation outlining the focus of your work.
NOTE: Your answer should not exceed **100** words.

1.4a	Has the lead partner previously received a BCPP grant?	Yes	No
	If no, please go to Q1.5.		

1.4b If yes, how many times has the lead partner received BCPP funding at each level?

Level 1		Level 2		Level 3	

1.4c Tell us how you will apply the learning from your previous project(s).

NOTE: Your answer should not exceed **200** words.

1.5 How many paid staff (full and part time) are there in the community partner organisation?

Mark one box only

	0 (The organisation is run by volunteers)
	Less than 5
	Less than 10
	Less than 30
	Less than 50
	51 – 100
	100 +

PART 2: Assessment

Please refer to the Guidance Notes for advice and examples on how to answer each question.

The area your project will work in:

2.1a Health and Social Care Trust Area(s)
2.1b Council Area(s)

2.1c Is your project mainly			
	Rural?	Urban?	Both?

2.2 Please provide the Super Output Area (SOA) and Multiple Deprivation Measure (MDM) rank which your BCPP group(s) will be coming from i.e. where do they live? This can be found at *www.nisra.gov.uk/ninis* (Max 4 SOA/MDM).

Super Output Area Names	**MDM Rank**

NOTE: One line of text per field only.

2.3 Please specify the *target group* you hope to work with e.g. men, women, older people, people who are homeless, street drinkers and *issues* you plan to address e.g. mental health, isolation, sexual health, dementia, housing, poverty.

Target Group	**Issues**

2.4 Provide a concise aim and summary of your proposed project.

NOTE: Your answer should not exceed **150** words.

2.5 Tell us why there is a need for this project in your area.

NOTE: Your answer should not exceed **500** words.

2.6 How will the Pharmacy Partner contribute to the project?

NOTE: Your answer should not exceed **250** words.

2.7 How will the Community Partner contribute to the project?

NOTE: Your answer should not exceed **250** words.

2.8 How will the group members (participants) contribute to the project? Think about how their skills and local assets will be used.

NOTE: Your answer should not exceed **250** words.

2.9 Which external organisations do you hope will deliver sessions in your project and why? Level 2 projects must work with a minimum of four external community/voluntary organisations.

NOTE: Your answer should not exceed **250** words.

2.10 Tell us more about your participants – Who are they? What will you do to recruit them and how will you keep them engaged in the project?

(Maximum 250 words)

2.11 What difference do you hope this project will make?
Think about the BCPP outcomes in your answer (see Guidance Notes P4).

NOTE: Your answer should not exceed **500** words.

2.12 Activity Plan – please explain what will happen, how often it will happen and who will be involved. Your Activity Plan must relate to your budget.			
Sessions/Activity	**Who is involved? Who is leading the session?**	**Total Number of attendees**	**Timescale**

2.13 Please provide your budget for the work (see Guidance Notes for a sample budget).		
Item	**Details including number of hours, rate per hour/day and number of sessions etc**	**Cost**
Pharmacy partner	10 lead sessions, 4 co-facilitated sessions, 2 training days and 3 planning days (£3,400)	**£3,400**
Lead partner: management plus administration		
External community/voluntary organisations, groups and agencies	4 x external community/voluntary partners @ £150 each per session	**£600**
Overheads including room hire, printing, stationery, photocopying, telephone and postage		
Monitoring and evaluation		**£2,000**
Other, for example, travel and subsistence, childcare		
Total Costs		**£12,000**

2.14 CDHN provides specific guidelines and mandatory training in relation to: **Evaluation, Finance, Community Development, Health Literacy & Health Inequalities** **I/we confirm that, if funded we will attend training and evaluate in accordance with BCPP requirements.**	Yes	No
2.15 I/we confirm that, both partners know we can sign up to free CDHN Membership.	Yes	No
2.16 I/We confirm that, if funded, I/we agree to adhere to BCPP publicity guidelines and take part in publicity for BCPP when appropriate	Yes	No
2.17 Have you had you accounts audited by an outside Auditor within the last year? Please send a copy or if you do not have audited accounts, send a copy of your most recent bank statement.	Yes	No
2.18 Does your project seek to promote the principles of Section 75 of the NI Act 1998?	Yes	No

2.19 If you are working with children or vulnerable adults do you have the appropriate policies and procedures in place to meet the relevant requirements?	Yes	No	Not applicable
2.20 If you are involving volunteers, do you have policies and procedures in place to support the effective management of volunteers?	Yes	No	Not applicable
2.21 If you are providing childcare for this project, do you have the appropriate policies and procedures in place?	Yes	No	Not applicable
2.22 If your project involves support services, do you have the appropriate principles of good practice in place?	Yes	No	Not applicable

2.23 As a Pharmacist working on the project, I confirm that my professional and personal conduct will comply with the Pharmaceutical Society of Northern Ireland's Code of Ethics. More information on this can be read at *www.psni.org.uk/about/code-of-ethics-and-standards*	
Pharmacist Name:	Signature:

PART 3: Applicant Declaration

I, the **lead applicant,** declare that:

	Mark box **X** agree
3.1 The information on this form is accurate and understand that if any information is inaccurate or incomplete, legal action may be taken against my organisation/business.	
3.2 The organisation/business has the authority to accept a grant and to repay the grant in the event of the grant conditions not being met.	

LEAD APPLICANT (Community or Pharmacy as stated in application)	
Name:	
Position:	
Signature:	
Organisation:	
Date:	

PARTNER ORGANISATION (Community or Pharmacy as stated in application)	
Name:	
Position:	
Signature:	
Organisation:	
Date:	

CHECKLIST

	Tick when completed
Have you completed every question?	
Have you adhered to the word limit for each question?	
Is the budget submitted within the grant limit?	
Have you kept a copy of the application for your own records?	
Is the community partner constitution attached to the application email?	
Is your most recent set of audited accounts or most recent bank statement (if pharmacy-led) attached to the application email?	
Have you signed your application? An electronic signature is acceptable at this stage.	

All applications must be emailed with the supporting documentation to bcpp@cdhn.org by the closing date.

Community Development and Health Network

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