

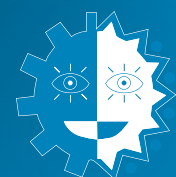


BCPP LEVEL 2 APPLICATION FORM (COVID-19)

**UP TO £12,000 AVAILABLE FOR A
PROJECT LASTING UP TO 12 MONTHS**

APPLICANT ORGANISATION NAME:

APPLICATIONS MUST BE COMPLETED USING **ADOBE
ACROBAT OR READER ONLY** AND SUBMITTED VIA EMAIL
TO **BCPP@CDHN.ORG** BY THE CLOSING DATE



**Community Development
& Health Network**

PART 1: Partner information

1.1a <u>Community</u> 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 <input type="checkbox"/> box only.	
<input type="checkbox"/> Community Partner	<input type="checkbox"/> 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
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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	
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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

<input type="checkbox"/>	0 (The organisation is run by volunteers)
<input type="checkbox"/>	Less than 5
<input type="checkbox"/>	Less than 10
<input type="checkbox"/>	Less than 30
<input type="checkbox"/>	Less than 50
<input type="checkbox"/>	51 – 100
<input type="checkbox"/>	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)

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2.1b Council Area(s)

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2.1c Is your project mainly

	Rural?	Urban?	Both?
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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(s)* 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(s)	Issues

NOTE: One line of text per field only.

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 What will you do to recruit participants and keep them engaged in the project?

NOTE: Your answer should not exceed **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		
Lead partner: management plus administration		
External community/voluntary organisations, groups and agencies		
Overheads including room hire, printing, stationery, photocopying, telephone and postage		
Monitoring and evaluation		
Other, for example, travel and subsistence, childcare		
Total Costs		

<p>2.14 CDHN provides specific guidelines and mandatory training (one day) in relation to: Evaluation, Finance, Community Development, Health Literacy & Health Inequalities</p> <p>I/we confirm that, if funded we will attend a one day training and evaluate in accordance with BCPP requirements.</p>	Yes	No	
<p>2.15 I/we confirm that, if funded, I/we agree to accept free membership of CDHN.</p>	Yes	No	
<p>2.16 I/we confirm that, if funded, I/we agree to accept free membership of CDHN. Your data will be processed in line with GDPR requirements (please refer to CDHN's Privacy Notice for further information).</p>	Yes	No	
<p>2.17 Have you had your accounts audited by an outside Auditor within the last year? Please send a copy or if you do you have the appropriate policies and procedures in place to the meet the relevant requirements?</p>	Yes	No	
<p>2.18 Does your project seek to promote the principles of Section 75 of the NI Act 1998?</p>	Yes	No	
<p>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?</p>	Yes	No	Not applicable
<p>2.20 If you are involving volunteers, do you have policies and procedures in place to support the effective management of volunteers?</p>	Yes	No	Not applicable
<p>2.21 If you are providing childcare for this project, do you have the appropriate policies and procedures in place?</p>	Yes	No	Not applicable
<p>2.22 If your project involves support services, do you have the appropriate principles of good practice in place?</p>	Yes	No	Not applicable
<p>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.pсни.org.uk/about/code-of-ethics-and-standards</p>			
Pharmacist Name	Signature		
<p>2.24 <u>For those projects meeting face to face, By signing below I/we confirm that there are protocols in place for meeting safely in light of COVID-19 and these will be adhered to in line with PHA guidance.</u></p>			
Partner Name	Signature		

PART 3: Applicant Declaration

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

Mark box
 to 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

Mark completed

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

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

Building the Community – Pharmacy Partnership Programme
Community Development and Health Network

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