**IMPORTANT INFORMATION:**

This form is to be used when seeking approval to determine a new [Fee or Charge](file:///W:\Finance\EPG\Health%20Finance\Revenue%20Strategy%20and%20Support%20Unit\Fees%20and%20Charges%20Manual\WA%20Health%20Fees%20and%20Charges%20Manual%202017-18.pdf).

If you require assistance in completing this form please contact the [RevenueStrategyandSupportUnit@health.wa.gov.au](mailto:RevenueStrategyandSupportUnit@health.wa.gov.au) in the first instance.

Once completed please submit the form to the above email address.

**PART A – APPLICANT DETAILS**

|  |  |
| --- | --- |
| Name: |  |
| HE Number: |  |
| Position: |  |
| Department: |  |
| Health Service: |  |
| Contact Number: |  |
| Officer Declaration:  I declare that the information provided on this form is true and correct to the best of my knowledge | Name:  Signature:  Date: |

**PART B – DESCRIPTION OF FEE OR CHARGE**

| Category of Fee or Charge: | [Health Services](W:\\Finance\\EPG\\Health Finance\\Revenue Strategy and Support Unit\\Fees and Charges Manual\\WA Health Fees and Charges Manual 2017-18.pdf)  [Other Goods and Services](W:\\Finance\\EPG\\Health Finance\\Revenue Strategy and Support Unit\\Fees and Charges Manual\\WA Health Fees and Charges Manual 2017-18.pdf) |
| --- | --- |
| Reason for New Fee or Charge: |  |
| Proposed Fee or Charge:  Please attach the Costing Methodology used to determine the Fee or Charge as an Excel spreadsheet | $ |
| Level at Which Fee or Charge will be set: | Cost Recovery  Above Cost Recovery  Below Cost recovery  Please provide an explanation on Additional Information sheet if above or below cost recovery |
| Proposed Effective Date: |  |
| Is Any Information Provided Subject To a Commercial In Confidence Agreement? | No  Yes  If Yes Provide explanation on Additional Information sheet |

**PART C – ENDORSEMENT**

This form must be signed by all parties prior to submission to the Department of Health

|  |  |
| --- | --- |
| Chair - Health Service Board: | Name:  Signature:  Date: |
| Chair - Finance Sub-Committee: | Name:  Signature:  Date: |
| Chief Executive Health Service: | Name:  Signature:  Date: |
| Chief Finance Officer: | Name:  Signature:  Date: |

**PART D – ADDITIONAL INFORMATION SHEET**

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