

STATE OF DELAWARE
HEALTH FUND ADVISORY COMMITTEE

APPLICATION FORM

FY 2007

FUNDING REQUESTS ARE DUE BY COB ON MONDAY OCTOBER 3, 2005 TO:
(Please submit the original document plus one copy)

**Lisa Schieffert
Chief Policy Advisor
Delaware Health & Social Services
1901 N. DuPont Highway
New Castle, DE 19720**

Official Name of Organization: _____

Date of Incorporation: _____

9 digit Federal Employer Identification No.

Contact Representative: _____

Phone Number (daytime): _____

Email: _____

YES NO

Did you receive a Health Fund Award in Fiscal Year 2006?

Are you a first time applicant?

Is your agency receiving or has your agency received any other state funds?

MANAGEMENT ORGANIZATION

Official Name of Organization: _____

Address of Management Office: _____

Street Address or Location: _____

Phone Number: _____

Contact Representative: _____

Name: _____

Address: _____

Phone Number: _____ (Daytime)

TARGET POPULATION: _____

AGENCY LOCATION(s) locations where services are actually provided:

FUNDING REQUEST: \$ _____

PROGRAM DESCRIPTION:

IF YOU DID NOT SUCCESSFULLY REACH YOUR PROGRAM GOALS HOW WOULD YOU MODIFY YOUR PROGRAM TO MEET THOSE OBJECTIVES?

IF YOU ARE A NEW APPLICANT HOW DO YOU ANTICIPATE EVALUATING YOUR PROGRAM'S SUCCESS (OUTCOME MEASURES)?

WHAT ARE THE OTHER SOURCES OF FUNDING FOR YOUR AGENCY?
(PLEASE LIST AGENCY AND AMOUNTS)

STATE FUNDS

FEDERAL FUNDS

OTHER FUNDS

ARE THERE OTHER AGENCIES THAT PROVIDE SIMILAR SERVICES AND DO YOU WORK IN COLLABORATION WITH THEM?

AGREES:

(Agency Name)

1. To submit funding requests on the forms provided at the times designated and to participate in the allocations review process.
2. To provide an annual certified audit and other financial statements, service figures, and reports or audits as required by the State of Delaware.
3. To cooperate with other organizations, both voluntary and public, in responding to the needs of the community and in promoting high standards of efficiency and effectiveness.
4. To submit accurate information with this application. NOTE: Any misstatement of facts may forfeit any remaining balance of grants due and/or future grants.
5. That this agency meets the criteria established the Health Fund Advisory Committee and uses any funds appropriated by the General Assembly in accordance with those provisions and any additional restrictions that may be set forth in the grant-in-aid legislation.
6. This agency will provide the Office of the Controller General with financial or programmatic information upon request.

This agreement has been read and approved at the meeting of the governing body of the agency on

(DATE)

AGENCY: _____

BY: _____

(President or Chairman)

(Executive Director)

DATE: _____