# Application Form

**Program (Applicants may not check more than one program). Applicants may submit more than one application. Checking more than one program will result in disqualification. Applicants must select at least one.**

[ ]  A1 – Independent Living Services

[ ]  A2 – Respite Services

[ ]  A3 – Positive Behavioral Supports (PBS)

1. **Organization Type**

[ ]  Public Agency [ ]  501(c)(3) Nonprofit

1. **Geographic Area of Service**

| [ ]  Town/City |  |
| --- | --- |
| [ ]  County |  |
| [ ]  Region |  |

**C. Applicant Organization**

| Name |  |
| --- | --- |
| Mailing Address |  |
| Physical Address |  |
| City |  | NV |
| Zip (9-digit zip required) |  |
| Federal Tax ID # |  (xx-xxxxxxx) |
| DUNS No.  |  |

1. **Program Point of Contact**

|  |  |
| --- | --- |
| Name |  |
| Title |  |
| Phone |  |
| Email |  |
| Same mailing address as section B? [ ]  Yes [ ]  No, use below address information |
| Address |  |
| City |  | NV |
| Zip (9-digit zip required) |  |

1. **Fiscal Officer**

| Name |  |
| --- | --- |
| Title |  |
| Phone |  |
| Email |  |
| Same mailing address as section B? [ ]  Yes [ ]  No, use below address information |
| Address |  |
| City |  | NV |
| Zip (9-digit zip required) |  |

1. **Key Personnel (Add Rows if Required)**

| **Name** | **Title** | **Licensed?** |
| --- | --- | --- |
| Project Manager |  | [ ]  Yes [ ]  No |
| Fiscal Manager  |  | [ ]  Yes [ ]  No |
|  |  | [ ]  Yes [ ]  No |
|  |  | [ ]  Yes [ ]  No |

1. **Experience (Must Select One). Select the box that most accurately describes the activities being proposed.**

**[ ]** Organization is 3+ years, proposed program is new

**[ ]** Existing Program 2-5 years old

**[ ]** Existing Program 6-9 years old

**[ ]** Existing Program 10+ years

|  |
| --- |
| Describe sustainability plan for services after 6/30/2023 |
|  |

**H. Third-Party Payers of Services**

| Does your organization or its subcontractors bill any third-party payers (e.g. insurance companies) for family planning services? [ ]  Yes, specified below [ ]  No |
| --- |
| **Third-Party Payers** | **Period** | **Billables Received ($)** | **Percentage of Operating Income (%)** |
| *Best Health Insurance (example)* | *2017 YTD* | *130,000* | *10* |
|  |  |  |  |
|  |  |  |  |

**I. Current Funding (federal, state, and private funding). Add rows as required. Describe all funding received for services and/or similar programs. If no additional funding is received, enter NOT APPLICABLE in this section.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Funding** | **Type** | **Project Period End Date** | **Current or Previous Amount Awarded ($)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**J. Certification by Authorized Official**

|  |
| --- |
| As the authorized official for the applying agency, I certify that the proposed project and activities described in this application meets all requirements of the legislation governing the Fund for a Healthy Nevada and the certifications in the Application Instructions; that all the information contained in the application is correct; that the appropriate coordination with affected agencies and organizations, including subcontractors, took place; that this agency agrees to comply with all provisions of the applicable grant program and all other applicable federal and state laws, current or future rules, and regulations. I understand and agree that any award received as a result of this application is subject to the conditions set forth in the assurances.  |
| **Name (type/print):**  | **Phone**  |
| **Title** | **Email** |
| **Signature** | **Date** |