

TRAUMA-INFORMED CARE

APPLICATION FOR AWARD

Email applications or questions to:

grants@idoc.idaho.gov

**The award application will remain open,**

**subject to the availability of funds.**

Awards will be considered on a first come first served basis.

**IDOC Trauma-Informed Care Application Round One**

**Applicant Information & Background**

Applicant Legal Entity Name: Click or tap here to enter text.

Mailing Address: Click or tap here to enter text.

Applicant Point of Contact (POC) Name: Click or tap here to enter text.

POC Email: Click or tap here to enter text.

POC Phone Number: Click or tap here to enter text.

Applicant Fiscal Point of Contact (FPOC) Name: Click or tap here to enter text.

FPOC Email: Click or tap here to enter text.

FPOC Phone Number: Click or tap here to enter text.

**Proposal Details**

**Proposal Category:** Indicate if this proposal is under Category 1- Supportive Services or Category 2- Direct Mental Health Services

**Total Request:** $Click or tap here to enter text.

**Proposal Name:** Click or tap here to enter text.

 Click or tap here to enter text.

 **Proposal Summary**: Click here and write a brief synopsis of the proposal and the project’s goal.

 **Detailed Proposal Description**: Click here to provide a detailed project description. Include availability for non-traditional hours, location, etc.

**Reporting:** Type “Yes” if you understand and agree to the data collection and reporting as outlined in this guide for the monitoring and verification of the project: Click or tap here to enter text.

**Project Timeline:** Type “Yes” to indicate you understand and accept the outlined terms, that this is for pilot projects that are completed no later than June 30, 2023.

**Budget Detail and Narrative:** Using your own form, attach a detailed Budget Worksheet to the Grant Application.

I, **ENTER NAME** , hereby certify that **ENTER ORGANIZATION NAME** understands and will comply with the terms and conditions of the IDOC Trauma Funding Program pilot and with all required State laws and regulations for program participation. I understand that only allowable costs, supported with receipts, will be reimbursed and that unallowable costs will be at my own expense.

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Signature

Authorized Agent Name: Click or tap here to enter text.

Date: Click or tap here to enter text.