

TRAUMA-INFORMED CARE

APPLICATION FOR AWARD

Email applications or questions to:

contracts@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 Two**

**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 Click or tap here to enter text.

**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: Click or tap here to enter text.

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

I, Click or tap here to enter NAME. , hereby certify that Click or tap here to 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

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

Date: Click or tap here to enter text.