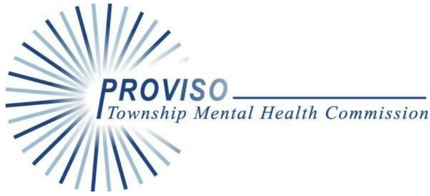


Funding Application
Fiscal Year 2020-2021

Thank you for your time and effort in completing this application.

If you have any questions please contact Director of Program Administration at 708-449-5508 or emails us at RTS@ptmhc.org

SECTION I.

Letter of Intent

Legal Name of Organization:

Mailing Address (and or Physical Address if it is different and not confidential):

Phone: **Fax:** **EIN:**

Website:

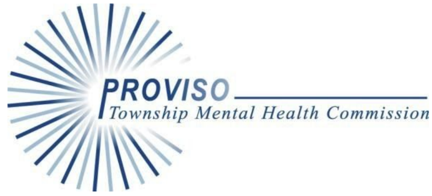
Name of CEO or Executive Director:

Phone: **Email:**

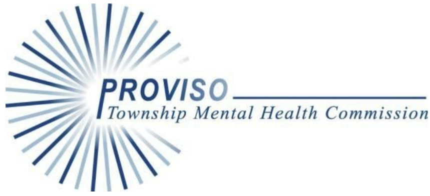
Program Name:

Program Contact & Title (if *not* the CEO or Executive Director)**:**

Phone: **Email:**



Funding Application
Fiscal Year 2020-2021



Organization Information

Year Incorporated:

Mission Statement:

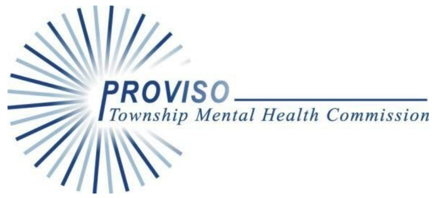
Geographic Area Served (specific to this proposal)**:**

Tax Exemption Status:

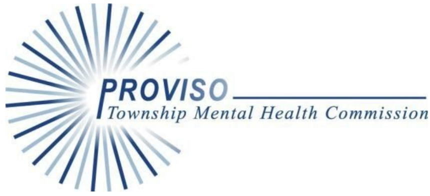
☐ 501(c)(3)
☐ Using a fiscal agent/fiscal sponsor
Name of fiscal agent/sponsor:
☐ Other than 501(c)(3), describe:

Estimated Clients Served by the Program: Proviso **Non-Proviso**

Number of Employees on the program: Full-time: **Part-time:**



Funding Application
Fiscal Year 2020-2021



Funding Application
Fiscal Year 2020-2021

Award Request Information

Type of Award Requested (select one)**:** **Amount of Request:** $

☐ Program or Project Support
Name of Program or Project:

☐ Other:

Describe what the award will be used for:

What discipline best describes the program?

☐ **Mental Health** ☐ **Substance Use** ☐ **Prevention**

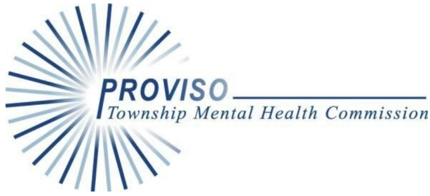
☐ **Intellectual/Develpmental Disability** ☐ **Other**

What service type best describes the program?

☐ **In-Patient** ☐ **Outpatient** ☐ **Group**
☐ **Individual** ☐ **Family**

☐ **Residential* (long term)** ☐ **Residential* (short term)**

***To qualify for financial support all residents must show 12 months of residency prior to the start of services**.



Funding Application
Fiscal Year 2020-2021

Financial Information

Budget numbers should match the numbers presented in the financial attachment.

Total Program or Project Budget: ______ **Dates: from:** __/__/__ **to:** __/__/__

Income: ______ **Expenses:** ______

What percent of the program's total cost is supported by other funding sources? List other funding sources and the funding amount.

Medicaid (if applicable)

A. **Provide a copy of the DHS certification outlining approved eligible services**
B. **Provide the organizations National Provider Identifier number (NPI).**

____

By signing below, I certify that the information contained in this application is true and correct to the best of my knowledge.

CEO/Executive Director ____________________________ **Date:** ______________