**DBHDS Jump-Start Funding Application**

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| **Contact Information**  |
| Date | Click here to enter a date |
| Agency Name | Click here to enter text |
| Agency Mailing Address | Click here to enter text |
| Agency Contact Representative | Click here to enter text |
| Contact Telephone Number | Click here to enter text |
| Contact Fax Number | Click here to enter text |
| Contact Email Address | Click here to enter text |
| **Current Services (submit current license and addendum with application, if applicable)** |
| **Enter address of cities/counties where services are offered** | **Services offered** | **Enter the number of people currently supported by the provider** |
| Click here to enter text | Click or tap here to enter text. | Click here to enter text |
| Click here to enter text | Click or tap here to enter text. | Click or tap here to enter text. |
| Click here to enter text | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Planned Services** |
| Describe provider’s history in providing DD waiver services in Virginia or another state | Click or tap here to enter text. |
| Attach organizational structure and staffing patterns. Include a description of the new service (s), including management that is connected to service, and key roles and responsibilities of staff. |
| Indicate if funding will result in the addition of new services and/ or expanded services and the number of people who will be supported in this proposed program | [ ]  New service(s) optionClick or tap here to enter text. | [ ]  Expanded service(s) optionClick or tap here to enter text. |
| Number of additional people to be served in new service(s)Click or tap here to enter text. | Number of additional people to be served in expanded service(s)Click or tap here to enter text. |
| Enter the additional cities/counties where services will be provided as a result of Jump-Start funding | Enter New Cities/Counties | Enter Service(s) |
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| Provide justification of need for new or expanded service(s)  | Click here to enter text |
| Indicate the services you are planning to offer with Jump-Start Funding. Funds may be requested up to the indicated amounts.(*check no more than two services*) | [ ]  Benefits Planning ($10,000)[ ] Community Coaching ($15,000) [ ] Community Engagement ($15,000)[ ] Community Guide ($15,000)[ ]  Electronic Home-Based Services ($10,000)[ ]  Employment and Community Transportation ($25,000)[ ]  Independent Living Supports ($25,000)[ ]  In-Home Support Services ($25,000)[ ]  Peer Mentoring ($10,000)[ ]  Private Duty Nursing and/or Skilled Nursing ($25,000) [ ]  **S**hared Living ($10,000)[ ] Supported Living ($25,000) |
| **Development Plan** |
| Attach a budget and the plan with a timeline for implementing the new service(s); list the sequence of activities.*[Describe in the attachment a project budget showing line-by-line costs and describe how cost effectiveness is addressed. Also, attach a plan for the new service(s) with a timeline for implementing the different aspects of this service. Please send three (3) estimates for any requested expenditure in excess of $1000. If you are unable to provide three estimates because the item/service being requested is specialized, please provide justification for committee review. You may be asked to produce estimates for any requested expenditures by the review committee.]* |
| Describe how the individuals identified will benefit from these changes. | Click here to enter text |
| **Funding Request** |
| **Category**  | **Description** | **Service** | **Total for this request** |
| Choose an item. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Choose an item. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| **Statement of Sustainability** |
| Describe how the provider will sustain service provision beyond receipt of Jump-Start funding.Click here to enter text |
| **Signatures** |
| Provider agrees to participate in a DBHDS program review upon request: [ ] Yes [ ]  NoProvider agrees to share program accomplishments upon request for two years from approval date: [ ] Yes [ ]  No**This application is submitted for consideration by:** **Agency’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name /Title Signature Date signed**Received by:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DBHDS representative Signature Date signed/received**Submit the completed application, copy of license, Jump-Start Acknowledgement & Assignment of Award form(s) (must be received before funds are distributed; minimum of three individuals), and program budget by secure email to:** jumpstart@dbhds.virginia.gov |

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