**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) option  Click or tap here to enter text. | | | Expanded service(s) option  Click 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  No  Provider 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](mailto:jumpstart@dbhds.virginia.gov) | | | | | | |

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