DBHDS
Virginia Department of Behavioral Health and Developmental Services

Jump-Start Funding Application

Contact Information		
Date		
Agency Name		
Agency Mailing Address		
Agency Contact Representative		
Contact Telephone Number		
Contact Email Address		
Indicate current services, DBHDS license and DMAS participation agreement or professional required credentials (submit copy of these documents with application, if applicable)		
Current program(s)	**DBHDS license type (if applicable) or professional credentials**	**DMAS participation agreement number**

Planned Services	
Describe provider's history in providing DD waiver services in Virginia or another state	
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) or expanded service(s) option and the number of people to be served. ◯ New Service ◯ Expanded Service
Enter the cities/counties where services will be provided because of Jump-Start funding	**Please review the Provider Data Summary Baseline Measurement Tool at DBHDS.virginia.gov**

Enter Cities/Counties	Enter Service(s)

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*)

- ☐ Behavioral Therapeutic Consultation ($15,000)
- ☐ 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 ($25,000)
- ☐ Shared Living ($10,000)
- ☐ Skilled Nursing ($25,000)
- ☐ Sponsored Residential-**Children** ($10,000)
- ☐ Supported Living ($25,000)

Funding Request

Category	Description	Service	Total for this request

Statement of Individual Benefit

Describe how the individuals identified will benefit from these purchases.	

Statement of Sustainability

Describe how the provider will sustain service provision beyond receipt of Jump-Start funding.

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 (if applicable), participation agreement, Jump-Start Acknowledgement & Assignment of Award form(s) (must be received before funds are distributed; minimum of three individuals), and program budget by email to: jumpstart@dbhds.virginia.gov

Clear Form

Rev 10.24.23