New York State Association
Of Day Service Providers
2019

THE MARY FRAWLEY MEMORIAL GRANT APPLICATION

(Please Print Information Below)

Agency Name & Program Name: ____

Type of Program (check one): ___Day Treatment ___Day Habilitation ___Pre-Vocational
___SEMP ___Community Habilitation

Program Address: ____

Applicant Name/Title:____

Applicant Telephone: (include area code): _______________________________________

Applicant Fax: ____

Applicant E-mail address: ____

Supervisor Name: (name of person supporting this project): ______________________________

Supervisor Address: ____

Supervisor E-Mail ____

NYSADSP Region (Check One): ___Central East ___Central West ___West ___Long Island ___ NYC ___Southeast

TITLE OF GRANT: ____
DATE OF APPLICATION: ____

Since this space is limited, you may attach additional pages to give thorough explanations. Samples or pictures may be provided electronically and will be forwarded to committee members.

1. Has this project already begun implementation? ___Yes or ___ No
   - If yes, note the implementation date____________.
   - If yes, note how this grant will assist in your efforts:

   ____
   ____
   ____
   ____
   ____
   ____

2. Describe the proposed project, including the key features of the project, the results that are expected and why you feel this project should be awarded to your program.

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____
____
____
____
____

3. Describe how the project will provide;

- Community Inclusion or Relationship Building:______________________________
  ____
- Consumer Participation:____
  ____
- Applicability to other day programs:______________________________________
  ____
- Community Awareness:____
  ____

4. Describe the cost of the project **Note : The grant will provide half the funding initially and the other half upon submission of necessary receipts and paperwork, so the agency will be responsible for half of the initial expenditures, pending reimbursement. Monies will not be awarded to cover staffing or consultant costs.**

ITEM:	**COST:**
TOTAL AMOUNT REQUESTED:	

5. Describe the agency commitment (funds, equipment, matching funds, administrative support, and itemized expenditures for requested funds)?

____
____

If the total requested amount can not be approved, will you accept a reduced amount?
Yes _____ No _______ Comments: ____________________________________

6. Describe the originality of this project. How was it developed? Where did the idea originate, what research went into this request?

____
____

7. Describe how this project will be sustained by your agency after the use of the grant monies.

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_________________________________ __________________________

Applicant Signature Date

_________________________________ __________________________

Executive Directors Signature Date

E-Mail Application to:

Michelle Jungermann
NYSADSP
Fax: (585) 396-3437 Phone: (585) 919-2024
E-Mail: mjungermann@ontarioarc.org

All applications must be received no later than <u>Friday May 17, 2019</u> to be considered.