ST. TAMMANY PARISH GOVERNMENT
Department of Health & Human Services

PUBLIC HEALTH MILLAGE APPLICATION FOR FUNDING

PROGRAM YEAR 2014

1. Organization Information

Proposed Project Title ____________________

Requested Public Health Funds ____________________

Name of Organization ____________________

Executive Director ____________________

501(c)3 Status Yes No Supporting Documents Attached

Tax ID Number ____________________

Physical Address ____________________

Mailing Address ____________________

Phone Number ____________________

Fax Number ____________________

Website ____________________

Project Manager ____________________

Phone Number ____________________

E-mail Address ____________________

2. Organization History and Experience

Using the space below, provide a brief history of the agency, including a description of the history, mission, services of the organization, description and experience of staff, and grant management experience :

3. Project Details

- **Proposed Project Title :** ______________________________

- **Priority Areas**
  Check which, if any, of the following areas the project/program will address:

Suicide Prevention	Information and Referral Services
Behavioral Health Counseling for Individuals	Rural Health Care Services
Preventive Healthcare Services	Nutrition
Case Management	Group Therapy/ Support Groups
Dental Care	Crisis Management Services
Community Outreach and Education	Other

- **Project Location & Service Area**
  In the space provided below, describe the location of the services (i.e. location of clinic or office, community-based program, etc):

- **Program Beneficiary Population**
  Select one of the following options to describe the target population:

Low- Income Population	Uninsured Individuals
Mentally Ill Individuals	Families of Mentally Ill Individuals
Elderly Individuals	At-Risk Children/Youths Ages ____ to ____
Suicidal Individuals	Other ________________________________

- **Beneficiary Goal**
  How many *unduplicated* individuals will this program serve? ________________________

4. Project Description

Using the space provided, describe the scope of work for the proposed project. Detail each service activity the program will undertake, describe the intake procedures, location and hours of operation, staff and outreach plan :

5. Project Need

In the space below, explain our community's need for this type of service and how the proposed project will address that need:

Do other organizations provide similar services that address the identified community need described above? How will the proposed project/program differ from similar programs?

6. Project Goals and Sustainability

- **Sustainability**
  Please answer the following questions in the space provided:

  If the proposed project is not awarded the full amount requested, will the organization be able to implement the project with partial funding?

  How will the organization continue to provide these services if public health funds are not awarded next year?

- **Program Milestones**
  In the space provided below, please outline the goals and milestones your organization will meet throughout the funding year. Include as much detail as possible, such as number or people served or units of service to be provided:

Quarter of Activity	Activity/Action
Quarter 1	
Quarter 2	
Quarter 3	
Quarter 4	

7. Proposed Budget

Use the chart below to detail the budget for the proposed project. Be sure to include other funding sources, if applicable, to demonstrate leveraging of funds.

Specific Cost Item/Description	**Funding Request**	**Other Funding Source**	**Other Funding Amount**	**Total Amount** PHM Funding + Other Source
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12				
TOTAL PHM FUNDS REQUESTED	**$**	**TOTAL PROGRAM COST (PHM FUNDING + OTHER)**		**$**

BUDGET CONTINUED ON NEXT PAGE

8. Budget Justifications

Please provide specific details as to how the requested amount for each line item was determined:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

Application Certification

Signatures of Organization Representative with **binding authority**
below certifies the following statements:

- Organization has no conflict of interests with Parish appointed or elected representatives and does not employ Parish appointed or elected representatives or their families.
- Authorized official certifies that this application package has been reviewed and all information provided in this application and attachments is true and correct.
- Organization understands that submission of this application is not a guarantee of funding. Public Health Millage awards are dependent upon available funding and will be based on approval and adoption of St. Tammany Parish Department of Health and Human Services' FY 2014 budget.

____ ____________________
Signature of authorized organization representative Date

____
Printed Name

____
Title

____
Organization

PLEASE MAIL THIS APPLICATION BY CLOSE OF BUSINESS
MONDAY, SEPTEMBER 30TH, TO THE FOLLOWING:

ST. TAMMANY PARISH GOVERNMENT DEPT. OF HEALTH & HUMAN SERVICES
PO BOX 628
COVINGTON, LA
ATTN: HAYLEY CALLISON