Infant safe sleep education, community outreach and family support.

CARING COMMUNITIES MINI-GRANT PROGRAM

APPLICATION

The Baby 1st Network administers CARING COMMUNITIES MINI-GRANT PROGRAM. See **Program Guidelines** for details. All applications must be completed and delivered by mail or email by **April 12, 2019**. Applications **will not** be accepted by fax.

Mail or email your completed application to:
Community of Care Mini-Grant Program
C/O Baby 1st Network
P.O. Box 403
Toledo, OH 43697
800-477-7437
info@baby1stnetwork.org

For questions regarding this application:
Please contact:
Dr. Stacy Scott, Executive Director
330-929-9911
stacy.scott@baby1stnetwork.org

DATE: _____

I. APPLYING ORGANIZATION

1. Organization Name: _____ **Year started:** ____

2. Address: _____

3. City, state, zip: _____

4. Website: _____

5. Telephone: (___) _____

6. Contact person/Title: _____

7. Contact email: _____

8. Alternate contact person/Title: _____

9. Tax exempt status: Is your organization a 501C3? ___ YES ___ NO. If not, please name fiduciary agent below:

Tax ID#: _____ **Fiduciary Agent**_____

10. Check one category that best describes your organization: ☐ Civic Assoc. ☐ Human Services ☐ Arts Organization ☐ Faith Based ☐ Other: _____(please explain)

11. Please provide a mission statement or brief history of your organization's role in the community. (Attach a maximum one additional page to complete if necessary. Please do not include other printed material, CDs, videos, etc.)

II. PROJECT SUMMARY (Attach a maximum one additional page to complete Section II if necessary.)

Must include how this activity will help establish a Community of Care (COC). The COC will work to build awareness and provide peer support to families that inexperience a loss of an infant. Explain how the project will be carried out; how the funds will be used and the expected results of the project.

12. A) Project Title: _____

B) Project Description: _____

_____

_____

_____

_____

_____

C) Project Start Date: _____ **Project End Date:** _____

D) Project Location (address including zip code): _____

_____

E) County where the activity/project will occur: _____

F) Do you have any project partners? If so, please list partners and their contribution (An organization may be considered a project partner if it is a co-sponsor of the project, or contributes cash, facilities, goods or services to the project):

G) Describe target audience/beneficiaries for your project:

H) Projected number of beneficiaries (Participants and/or Audience): _____

I) How will *the Community of Care Mini-Grant program* improve or enhance your project?

J) Attach a project budget. Must include a detailed listing of income (both cash and in-kind) and a detailed listing of expenses.

13. Request: (maximum $500) _____

Project Budget Template (Please complete this form)

Project Activity: $_____

Justification: (E.g. Door Prizes and raffle items)

_____
_____

Design/Printing/Duplication of Project Materials $_____

Justification: (E.g. Print copies of the workshop flyers and assessment forms)

_____
_____

Facility Rental $_____

Justification: (E.g. Room rental for event)

_____
_____

Equipment Rental $_____

Justification: (E.g. Projection screen rental fee for PowerPoint presentations)

_____
_____

Mileage $_____

Justification: (E.g. Mileage supporting miles traveled to conduct community event)

_____
_____

Honorarium $_____

Justification: (E.g. Donation for a Bereavement Specialist)

_____
_____

General Supplies $_____

Justification: (E.g. Purchase of pens and 100 gift bags to provide to each participant)

_____
_____

III. SIGNATURE

Authorized Official's Signature: _____ **Date** _____

Print Name: _____

Print Title: _____