Health Services

Application for Senior Citizen Millage Funds for Calendar Year 2011

Date of Application ________________________________

Name of Service Provider ________________________________

Name of Program ________________________________

Mailing Address ____________________ City____________________ Zip__________

Phone Number________________________________

Person in Charge ________________________________

Title________________________________

Days and Hours of Service________________________________

Are you a new organization? Yes _____ No _____

Is your organization registered with the State of Michigan? Yes _____ No _____

Is your organization a 501 (c) (3) organization? Yes _____ No _____

Official name: ________________________________

Date Established ________________________________

Senior Millage Funds requested amount $ ________________________________

How many units of service do you plan to provide in ***2011*?** __________________

What is your total unit cost (county dollars requested divided by # of anticipated units of service (Note: One hour equals one unit of service) ____________________

Is the requested amount for a new program? Yes _____ No _____

Will this request involve additional employees? Yes _____ No _____

If involves additional employees, how many? ________________________________

Number of paid employee's Full time ______ Part time ______

Name, Title and County of Residence of Officers:

Name	Title	County

(Attach sheets as needed)

Indicate the Number of Unduplicated Clients Served in the Last Twelve Months:

Azallia	48110	___________	Monroe	48161	___________
Britton	49229	___________	Monroe	48162	___________
Carleton	48117	___________	Newport	48166	___________
Deerfield	49238	___________	Ottawa Lake	49267	___________
Dundee	48131	___________	Petersburg	49270	___________
Erie	48133	___________	Riga	49276	___________
Ida	48140	___________	Samaria	48177	___________
Lambertville	48144	___________	S. Rockwood	48179	___________
LaSalle	48145	___________	Temperance	48182	___________
Luna Pier	48157	___________	Willow	48191	___________
Maybee	48159	___________			
Milan	48160	___________		**Total**	___________

How many of these clients are 60+ ___________

- Indicate the percentage of anticipated unduplicated clients you plan to serve ___________
- Indicate the number of anticipated unduplicated clients you plan to serve _____________
- Geographic Area planned to be served ____________________

Explanation of Funding Request

Briefly describe the program for which funds are requested:

____

____

Explain the need for your program and its relevance to improving the quality of life for Monroe County seniors:

____

____

Have similar programs been undertaken by other organizations in the community? Please explain.

____

____

How will you evaluate the success of your program?

____

____

Other funding sources you applied to for this program:

____

____

If this program will be a continuing one, explain in detail the source of funds for operations and salaries in future years:

____

____

If the Monroe County Commission on Aging does not approve your request for funds, what alternate plan would you follow?

____

____

____

Do you charge, or request a donation from the seniors for any services or activities?

Yes _________ No __________ If yes, please, list services and associated fees:

____________________________________ ______________________________

____________________________________ ______________________________

What programs or activities do you provide weekly? Please also list programs or activities provided other than weekly and specify frequency. Narrate below and add additional sheets if necessary.

____

____

On the average, how many hours do you anticipate that volunteers will contribute to the program each week? ____________________

Of these, how many hours are not counted by RSVP? _____________________

Do employees in your organization receive paid lunchtime? Yes ______ No ______

If yes, how long? __________________

Explanation of Request for Funding Increases

Salary Increase of ____ % or $ ____ per hour for the following positions:

____
____
____
____
____
____
____
____

- ❖ What percent of the agency salary costs are charged off to the senior millage? _________%
- ❖ What percent of agency fringe benefits costs are charged off to the senior millage? _________%

Fringe benefit increases

- ❖ Worker's Compensation ______________________________
- ❖ Health Insurance ______________________________
- ❖ Other (Specify) ______________________________

Operations increases for the following line items:

____
____
____
____
____
____
____
____

Additional staff/additional time for existing part time staff:

Position title	Wage per hour	Fringe benefits	Hours per week

(Attach sheets as needed)

Budget Summary

	2010	2011
County Dollars requested for salaries		
County Dollars received for salaries		########################
County Dollars requested for operations		
County Dollars received for operations		########################
Total County Dollars requested for calendar year		
Total County Dollars received for calendar year		########################
Total additional County Dollars received throughout budget year		########################
Total cost of program		
Percent of Total Program cost required from County Dollars		

I assure The Monroe County Commission on Aging that all the information provided herein is current and accurate, any County funds granted will be used expressly for the purposes requested, and that all services and activities will be operated in accordance with State and Federal Laws, Monroe County Commission on Aging Regulations, Policies, and Procedures.

Print Name ______________________ Signature ________________________ Title __________________

Program ______________________ Date __________________