

# Senior Centers

## Application for Senior Citizen Millage Funds for Calendar Year 2010

Date of Application \_\_\_\_\_

Name of Service Provider \_\_\_\_\_

Name of Program \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Person in Charge \_\_\_\_\_

Title \_\_\_\_\_

Days and Hours of Service \_\_\_\_\_

How many paid members do you have as of this date? \_\_\_\_\_

Are you a new organization? Yes \_\_\_\_ No \_\_\_\_

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

Revised 071309

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 **2010**? \_\_\_\_\_

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

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

<u>Name</u>	<u>Title</u>	<u>County</u>						
			Azallia	48110	_____	Milan	48160	_____
			Britton	49229	_____	Monroe	48161	_____
			Carleton	48117	_____	Monroe	48162	_____
			Deerfield	49238	_____	Newport	48166	_____
			Dundee	48131	_____	Ottawa Lake	49267	_____
			Erie	48133	_____	Petersburg	49270	_____
			Ida	48140	_____	Riga	49276	_____
			Lambertville	48144	_____	S. Rockwood	48179	_____
			LaSalle	48145	_____	Temperance	48182	_____
			Luna Pier	48157	_____	Willow	48191	_____
			Maybee	48159	_____	<b>Total</b>		_____

(Attach sheets as needed)

- ❖ Indicate the number of anticipated unduplicated clients you plan to serve \_\_\_\_\_
- ❖ How many of these clients are 60+ \_\_\_\_\_
- ❖ Geographic Area planned to be served \_\_\_\_\_

## ***Explanation of Funding Request***

Briefly describe the program for which funds are requested:

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

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

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How will you evaluate the success of your program?

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Other funding sources you applied to for this program:

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

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

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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:

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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.

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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:

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Operations increases for the following line items:

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❖ 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?  
\_\_\_\_\_ %

**Additional staff/additional time for existing part time staff:**

Position title	Wage per hour	Fringe benefits	Hours per week
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Fringe benefit increases**

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

(Attach sheets as needed)

**Budget Summary**

	2009	2010
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, and that 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 \_\_\_\_\_