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| **Dan Thompson Memorial Developmental Disabilities Community Services Account Application** |
| **Organization Name** |  |
| **Date of Submission** |  |
| **Contact Person** |  |
| **Business Address** |  |
| **Phone Number** |  |
| **Email Address** |  |
| **Website** |  |

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| **Project Proposal** |
| **Have you applied for Dan Thompson Grant Funding before?** |  |
| **Requested Amount of Funds** |  |
| **Topic Area** |  |
| **Counties impacted (or Statewide)** |  |
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| **Briefly describe your project proposal in three sentences:** |
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| **Describe how your project proposal will improve or expand the Medicaid State Plan or the Home and Community Based Services Waivers:** |
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| **What are you planning to accomplish, and how will you reach that goal within the contract timeline? Please describe each specific and measurable outcome of your proposal.** |
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| **What is the detailed timeline for your project? Describe how you will make sure the project is complete by June 2027.** |
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| **Describe how your proposal provides a direct benefit for people who are eligible to receive DDA services.** |
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| **Describe how you will collect the data and measure the impact of your proposal** |
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| **Describe the roles and responsibilities of each role directly involved with your proposal:** |
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| **Describe the knowledge and skills possessed by the organization that are needed to implement the proposal**  |
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| **Describe your proposal’s risks**  |
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| **What are your contingency plans?** |
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| **Describe any additional funding sources for this proposal.** |
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| **What is the sustainability plan for the project you are proposing?** |
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| **Please provide budget details below** |
| **Budget Item** | **Budget Amount** |
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| **Supplemental Section** |
| **Are you registered to do business in Washington State?**Yes [ ] No [ ]  |
| **Are you a small business owner and controlled by a minority, women, or socially and economically disadvantaged persons, or a veteran owned business?**Yes [ ] No [ ]  |
| **Do you work with under-served communities besides those related to developmental disabilities?**Yes [ ] No [ ]  |
| **I understand no work described in this application can start before a signed and fully executed contract is in hand** | Acknowledged [ ] Name of Applicant:Click or tap here to enter text. |
| **I understand that I will need to be a registered business in the state of Washington and meet DSHS insurance requirements in order to receive a grant award** | Acknowledged [ ] Name of Applicant:Click or tap here to enter text. |
| **I understand this is a reimbursement-based contract with no advanced payments allowed** | Acknowledged [ ] Name of Applicant:Click or tap here to enter text. |
| **Signature** |  |
| **Date** |  |