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|  | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES (RCS)  ADULT FAMILY HOMES (AFH)  **AFH State Civil Penalty Reinvestment Program Grant Application** | |
| Review the [instructions](http://forms.dshs.wa.lcl/formDetails.aspx?ID=60279) document when completing this application. This application is only to be used to apply for funding projects benefiting residents of an Adult Family Home (AFH). Applications will only be accepted between June 1 and July 31. Any questions or completed applications should be sent to [scprprogram@dshs.wa.gov](mailto:scprprogram@dshs.wa.gov). | | |
| **Section 1. Applicant Information** | | |
| 1. NAME OF APPLICANT ORGANIZATION | | |
| 1. MAILING ADDRESS CITY STATE ZIP CODE COUNTY | | |
| 1. PRIMARY CONTACT PERSON | | |
| 1. EMAIL | | 1. TELEPHONE NUMBER |
| 1. WEBSITE | | |
| 1. IS THE APPLICANT AN AFH PROVIDER?   Yes  No. If no, what type of organization is the applicant? Please also attach references to support your application from a provider, provider association, the Ombuds, or other group. | | |
| 1. DESCRIBE YOUR ORGANIZATION; IF THE ORGANIZATION IS NOT AN ADULT FAMILY HOME, DESCRIBE THE RELATIONSHIP WITH ADULT FAMILY HOMES (E.G. MISSION STATEMENT, NUMBER OF YEARS OF SERVICE, ETC.) | | |
| **Section 2. Description of Project** | | |
| 1. PROJECT TITLE | | |
| 1. TIMELINE FOR PROJECT   Length Start date: Projected end date: | | |
| 1. PROJECT CATEGORY   Culture Change / Direct Improvements to Quality of Life  Direct Improvements to Quality of Life  Training  Client Information  Quality Assurance and/or Performance Improvement  Other, please specify: | | |
| 1. DESCRIBE THE PROJECT AND ITS PURPOSE | | |
| 1. WHY ARE YOU PROPOSING THIS PROJECT FOR THIS GROUP? DESCRIBE THE BENEFIT TO AFH RESIDENTS, INCLUDING WHY YOU BELIEVE YOUR POPULATION WILL BENEFIT AND BE INTERESTED IN PARTICIPATING IN THE PROJECT. THIS MAY ALSO INCLUDE HOW IT WILL BENEFIT THE HOME OVERALL, SUCH AS STAFF DEVELOPMENT OR QUALITY OF SERVICES PROVIDED, AND ANY RESEARCH THAT HAS BEEN DONE ON THE EFFECT OF THIS TYPE OF PROJECT ON LONG-TERM CARE RESIDENTS. | | |
| 1. DESCRIBE THE ORGANIZATION’S ABILITY TO COMPLETE THE PROJECT, INCLUDING RESOURCES RELEVANT TO THE PROPOSED PROJECT. WHO WILL BE DOING THE WORK OF THE PROJECT AND WHAT ARE THEIR QUALIFICATIONS? | | |
| **Section 3. Description of Costs** | | |
| 1. PROVIDE THE AMOUNT REQUESTED FOR THE PROJECT.   Total amount requested: $  Total non-SCPRP funds received or anticipated for the project: $  Estimated number of residents who will benefit:  Estimated dollar spent per resident: $ | | |
| 1. HAVE YOU ATTACHED A DETAILED LINE ITEM BUDGET TO THE APPLICATION?   Yes  No (note that applications received without a detailed line item budget will be considered incomplete. Use [DSHS 19-237](http://forms.dshs.wa.lcl/formDetails.aspx?ID=60280) Budget template.) | | |
| 1. EXPLAIN HOW YOU CALCULATED COSTS. IF THERE ARE COSTS THAT DO NOT DIRECTLY BENEFIT RESIDENTS, EXPLAIN WHY THEY ARE NEEDED. | | |
| 1. DESCRIBE ANY OUTSIDE FUNDING SOURCES OR OUTSIDE PARTNERS ON THE PROJECT. | | |
| **Section 4. Project Deliverables and Monitoring** | | |
| 1. LIST THE PRODUCTS THAT WILL BE PURCHASED OR PRODUCED FOR THIS PROJECT (E.G. ELECTRONICS OR OTHER EQUIPMENT, TRAINING MATERIALS, CURRICULA, ETC.). | | |
| 1. WHAT PERFORMANCE METRICS WILL YOU USE TO DEMONSTRATE THE EFECTIVENESS OF THE PROJECT? PLEASE DESCRIBE HOW YOU WILL DETERMINE IF THE PROJECT IS ACHIEVING THE DESIRED OUTCOMES, PARTICULARLY ANY IMPACT ON ADULT FAMILY RESIDENTS. INCLUDE INFORMATION ABOUT ANY SPECIFIC EVALUATION TOOLS YOU WILL USE IN REPORTS TO THE DEPARTMENT. | | |
| **Section 5. Conflicts of Funding or Other Requirements** | | |
| 1. DESCRIBE HOW THIS PROJECT DOES NOT DUPLICATE EXISTING REQUIREMENTS FOR THE PROVIDER OR OTHER FEDERAL OR STATE SERVICES. | | |
| 1. DESCRIBE HOW THIS PROJECT DOES NOT DUPLICATE FUNDING FOR SERVICES. | | |
| **Section 6. Risks and Sustainability** | | |
| 1. HOW WILL YOU CONTINUE THE PROJECT AFTER THE GRANT HAS ENDED? | | |
| 1. DESCRIBE POTENTIAL RISKS OR BARRIERS ASSOCIATED WITH IMPLEMENTING THIS PROJECT AND THE PLAN TO ADDRESS THESE CONCERNS. | | |
| **Section 7. Applicant Certification Signature** | | |
| SIGNATURE OF APPLICANT DATE | | |
| PRINTED NAME OF APPLICANT | | |