DCHD PROPOSAL ACTIVITY/PARTNER SUPPLEMENT FORM

(IF APPLICABLE)

If your project will be carried out in more than one physical location, complete an **Activity Supplement** for *each activity and location*. Each Partner or Consultant that will be providing direct services as a part of this project and is projected to receive $5,000 or more in funding must complete a **Partner Supplement**. Job Descriptions must be attached for all DCHD funded staff. If the project is funded, all contractual requirements and obligations of the fiscal manager will be passed on to the Partners.

AGENCY NAME:	**AGENCY ADDRESS:**
PROJECT NAME:	**DIRECTOR:**
CONTACT PERSON (NAME/TITLE):	**E-MAIL ADDRESS:**
PHONE NUMBER:	**# OF OVERALL CLIENTS SERVED:**
# OF DCHD CLIENTS SERVED:	**# OF OVERALL UNITS PROVIDED**
# OF DCHD UNITS:	

PROJECT SUMMARY: Briefly describe your role in the provision of services for this project

BUDGET

COST COMPONENT	DCHD FUNDING REQUEST	OTHER CASH	IN KIND	TOTAL PROJECT COST (NO IN-KIND)
TOTAL				

I certify that I am authorized to sign legal documents on behalf of this organization.
I certify that the information contained in this funding application is true and correct.

Signature **Print Name** **Date**