## **New Jersey Department of Health**

## APPLICATION FOR MINI-GRANT FUNDS (\$36,000 or Less)

(TYPE OR PRINT ALL DATA)

FOR STATE USE ONLY	_
Spending Plan No.	
Funding Authorization No.(s)	

1.	Name of Applicant										
2.	Street Address	City			County		Sta	ite	Zip Co	de	
3.	Name and Title of Fiscal Contact	t				Telephone	No.				
	Street Address					County					
	City	State	1	Zip Cod	е	Email Add	ress				
4.	Name of Attorney for Agency					Telephone	No.				
5.	Name and Title of Principal Cont	tact				Telephone	No.				
	Email Address 6. Employer ID No.			D No.		7. Certificate of Need Project (if applicable)  PENDING NOT REQUIRED					
8.	Proposed Grant Title			9. Locat	tion of Proposed Project (include county)						
	10. Site Locations  Number  ATTACH ADDITIONAL SHEETS							SHEETS			
11.	Will any member of the Board monetary gain from the fundir     Does any member of the Board committee or Task Force white	ng of this grant? ard of Directors/Trustees :	serve on any b	oard, cou	ıncil commission,	, _	YES YES		ON [		
		EMBER		-		OARD, CO	UNCIL,	ETC.		-	
	c. Type of payment plan preferre  Cost-Reimbursement	ed Advance Payment	11d. Locat	ion wher	e payments shou						
12.		GOVERNMENT [] OTHER (Specify)	] HOSPITAL		13. Does the Ag Requirements?	-	the folio	owing Lic NO	ensure PENDINO	G N/A	
14.	gency Fiscal Year End  15. Agency Accounting System:  Cash Basis  Other (Specify)  Accrual Basis			FOR SERVICES [ FOR PERSONNEL [							
16. Type of Request  NEW RENEWAL OF GRANT NO.:  MULTI YEAR GRANT MODIFICATION TO GRANT NO.:  YEAR: 1 2 3			16a. Budget Period Mo./Day/Yr.  From: Through: b. Project Period Mo./Day/Yr.  From: Through:								
17.	17. Is political subdivision covered by NJ Civil       18. Affirmative Action Plan         Service Merit System?       □ YES       □ NO				19. If grant is awarded, will funds be used to replace other funds which would be available in absence of award?  ☐ YES ☐ NO						
00.	Total Foreda Novelad		COST OF				F				
	a. Total Funds Needed		Requested fro			c. Funds	From O	ther Sou	rces		
21a. Name of NJDOH Representative Regarding Application 21b. Program (Granting Agency)											
22.	22. CERTIFICATION – The applicant certifies that to the best of his/her knowledge and belief all data supplied in this application and attachments are true and correct, the document has been duly authorized by the governing body of the applicant and further understands and agrees that any grant received as a result of this application shall be subject to the grant conditions, and other policies, regulations and rules issued by the New Jersey Department of Health which include provisions described in grant application instructions.							ids and			
NAME AND TITLE OF APPLICANT (Print) SIGNATURE OF APPL			CANT DATE OF APPLICATION					ATION			

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(Attach additional sheets if necessary.)

ASSESSMENT OF NEED(S) - List the need(s) that illustrate the reason for the project:
OBJECTIVE(S) OF PROJECT - List what will be done to alleviate "Needs" described above:
COST OF PROJECT - Indicate costs related to project: