REGIONAL CONSUMER ADVISORY COUNCIL (RCAC)
MINI-GRANT APPLICATION 2015-16
Application Due Date: November 4, 2015

*********<u>***Three copies of this proposal are required for review.***</u>*********

Name(s) of Applicants	Home Address & Town	Phone
1.		
2.		
3.		
4.		

Signature of Project Leader: _____ Date: _____
This signature attests that I am an adult in recovery from psychiatric and/or addiction disorder, a resident of North Central CT, aged eighteen years or older.

PROJECT NAME: _____

AMOUNT REQUESTED: $_____

BRIEF SUMMARY OF THE PROJECT:

PRIORITY AREA(S) ADDRESSED BY THIS PROJECT:

- ☐ 1. **Advocacy**
- ☐ 2. **Wellness**
- ☐ 3. **Creativity**
- ☐ 4. **Education** (training, conference, skill)
- ☐ 5. **Technology**

<u>RE</u>COVERY AREA TO BE ADDRESSED:
☐ Addiction ☐ Psychiatric ☐ Both

GEOGRAPHIC AREA TO BE SERVED BY THIS PROJECT:
☐ Town(s): _____
☐ County
☐ All of North Central CT

ESTIMATED NUMBER OF ADULTS ASSISTED BY THIS PROJECT: _____

Project Name: _____

AGENCY AUTHORIZATION - FIDUCIARY

By signing below, I:

State that I am authorized by the agency's Board of Directors to sign grants and contracts, my agency has non-profit status with a 501(c)3 certificate,

and

I agree to have my agency serve as fiduciary agent for the consumer-led project under this grant application and to comply with policy set forth in Fiduciary Role and Responsibilities on page 3.

_____
Signature

_____
Printed Name

_____
Title

_____
Agency

_____
Address

_____
Phone & Fax

_____
Email

_____
Date

*********<u>***Please read the following page detailing fiduciary's role***</u>***.***

Project Name: _____

FIDUCIARY ROLE & RESPONSIBILITY

Fiduciary Qualifications: You have the authority to manage finances for your non-profit agency. E.g., Executive Director, Chief Financial Officer or Board Chair.

Financial Reports: Monthly financial reports are required January-June 2016. Please Email to phamilton@ncrmhb.org, Consumer Initiatives Coordinator, Phoebe Hamilton. Phone 860. 667-6388.

Preventing Fraud: Please provide accounting staff copies of all mini-grant materials for tracking purposes. In the event of partial funding, RCAC Awards letters specify approximate sums for specific, approved budget items. Should a request come in that is not listed in these documents, please report to NCRMHB immediately and freeze balance of funds.

Releasing Funds: Please make grantees aware of Payroll schedule at start-up of project. Release funds as scheduled to allow grantees to remain on project timelines. If there are issues causing delays, due to agency or grantee's circumstances, please make us aware of any challenges.

RCAC Mini-Grants Deadline is June 8, 2016

****Please return unspent grant balances by this date****

Make checks out to:

North Central Regional Mental Health Board (RCAC Grant in memo area)

Mail attention to: RCAC

North Central Regional Mental Health Board
367 Russell Rd., Cottage 34, Newington, CT 06111

Contact:

Phoebe Hamilton, Consumer Initiatives Coordinator / RCAC Staff
North Central Regional Mental Health Board
(860) 667-6388 ext. 18, 10:30 a.m. - 4:30 p.m., e-mail: phamilton@ncrmhb.org

Project Name: _____

PROJECT DESCRIPTION

1. Briefly describe the proposed project. (You may add one additional page here).

Project Name: _____

2. Please explain how this project addresses the priority area(s) selected on page one.

3. Additional names of Adults in Recovery who helped create this project.

4. Why do you believe this project is needed?

5. Upon completion, how will you determine this project's success?

6. Will the project continue operation after its deadline? How will this be accomplished?

Project Name: _____

PROJECT WORKPLAN

PRIORITY AREA(S): _____

MAJOR ACTIVITY/OBJECTIVE:		
STEPS: *What is the activity being done?*	*Who will do it?*	*Date Completed?*
RESULT:		

You may add another page, if needed.

Project Name: _____

BUDGET FORM

Expense Item	*Amount Requested*
Materials and Supplies	
Facility Costs	
Communication Costs	
Food/Refreshments	
Consultant/Trainer	
Mileage/Travel	
Insurance	
Equipment	
Other (specify)	
TOTAL	**$** 0.00

***** Itemize expenses listed above, include names of retailors and/or consultants.**
ATTACH Proof of Equipment Costs using retail ads from internet, catalogue or newspaper.

BUDGET REFERENCE

Materials & Supplies: Consumable materials such as paper, pens, folders, etc.

Facility Costs: Room rental

Communication Costs: Postage, Telephone, Fax

Food/Refreshments: Food/beverages purchased for activities.

Consultant/Trainer: A contracted person who provides a service.

Mileage/Travel: Estimated transportation costs to perform an activity.

Insurance: Liability insurance covering participants involved in an activity.

Equipment: Costs for durable equipment such as computers, tools, sewing machines, etc.

Other: Specify costs from any other category not listed above.