Missouri Department of Public Safety

Application for Funding

2017 Fallen Services Workers Reimbursement Program

Agency Name:_____

Submitted Date:_____

Primary Contact

Name:_____
Job Title:_____
Email:_____
Street Address:_____
City/State/Zip:_____
Phone:_____
Fax:_____

Organization Information

Name of Applicant Agency:_____
Organization Type: _____
Federal Tax ID#: _____
Organization Website:_____
Mailing Address:_____
Street Address:_____
City/State/Zip:_____
Phone:_____
Fax:_____

Contact Information

Authorized Official (The Authorized Official is the individual that has the ability to legally bind the applicant agency in a contract, e.g. Board President, Executive Director)

Authorized Official's Name:_____
Job Title:_____
Agency:_____
Mailing Address:_____
Street Address:_____
City/State/Zip:_____
Email:_____
Phone:_____
Fax:_____

Project Director (The Project Director is the individual that will have direct oversight of the reimbursement program)

Project Director's Name:_____
Job Title:_____
Agency:_____
Mailing Address:_____
Street Address:_____
City/State/Zip:_____
Email:_____
Phone:_____
Fax:_____

Project Contact Person (The Project Contact Person should be the individual who is most familiar with the reimbursement program. This person can be the Project Director)

Project Contact Person's Name:_____
Job Title:_____
Agency:_____
Mailing Address:_____
Street Address:_____
City/State/Zip:_____
Email:_____
Phone:_____
Fax:_____

Fiscal Officer (The Fiscal Officer is the individual who has the responsibility for accounting and audit issues at the applicant agency level)

Fiscal Officer's Name:_____
Job Title:_____
Agency:_____
Mailing Address:_____
Street Address:_____
City/State/Zip:_____
Email:_____
Phone:_____
Fax:_____

Non-Profit Chairperson (Provide the name and address of the individual serving as the organization's board president. Also provide an address other than the agency address)

Non-Profit Chairperson's Name:_____
Job Title:_____
Agency:_____
Mailing Address:_____
Street Address:_____
City/State/Zip:_____
Email:_____
Phone:_____
Fax:_____

Project Summary

Application Type:_____
Geographic Area Served:_____

History of the Agency (Provide a brief history of the agency and the services it provides; when it was founded, number of fallen service workers' families served over the past three (3) years, total dollars awarded each of the past three (3) years, how much of the agency's total budget was used to assist families and their dependents over the past three (3) years, etc.) *(Attach additional pages if necessary)*

Statement of the Problem (This section must address the need for reimbursement funds. Please identify other funding sources received over the past three (3) years and the dollar amount allocated to assist families of fallen service workers and their dependents. Describe shortfalls that create a need for additional funds. Provide agency and local statistics for serving fallen service workers and their dependents.) *(Attach additional pages if necessary)*

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Type of Program (Outline the process in which a family applies for financial assistance services provided by the reimbursement program. Define what services are provided, how they are accessed and who benefits from reimbursement.) *(Attach additional pages if necessary)*

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Total Agency Operating Budget:_____

Budget Dedicated to Assist Families:_____

Total Project Cost (Indicate the agency's total dollar amount of reimbursement authority requested)

_____

Number of Families Served (Indicate the estimated number of fallen service workers' families to be served by this reimbursement program. Provide statistics from last year)

_____
_____

Breakdown of Financial Assistance (Provide statistics from the last three (3) years. Indicate number of families served, the amount awarded and type of assistance provided. Track this information for the current reimbursement cycle and submit as an Excel Spreadsheet. This data is used for both tracking and statistical purposes)

Assistance Provided	Number of Families Served			Dollar Amounts Awarded		
	2014 /	2015 /	2016	2014 /	2015 /	2016
Housing	/	/		/	/	
Utilities	/	/		/	/	
Education	/	/		/	/	
Daycare	/	/		/	/	
Medical	/	/		/	/	
Insurance	/	/		/	/	
Miscellaneous financial obligations	/	/		/	/	

Audit Requirements

Date last audit was completed:_____
Date(s) covered by last audit:_____
Last audit performed by:_____
Phone number of auditor:_____
Date of next audit:_____
Date(s) to be covered by next audit:_____
Next audit will be performed by:_____

Application Certified Assurances

To the best of my knowledge and belief, all data in this application is true and correct, the document has been duly authorized by the governing body of the applicant, and the applicant attests to and/or will comply with the Certified Assurances governing the Fallen Service Workers Reimbursement Program if the assistance is awarded.

I am aware that failure to comply with any of the Certified Assurances could result in funds being withheld until such time that I, the recipient, take appropriate action to rectify the incident(s) of non-compliance.

I have read and agree to the terms and conditions of the reimbursement award.

Your name and signature, represents your legal binding acceptance of the terms of this application and your statement of the veracity of the representations made in this application.

Title: _____
Authorized Official Name:_____
Signature:_____
Date:_____