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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01999 (09/2019) | | |  | | | | **STATE OF WISCONSIN** | | |
| **FOSTER GRANDPARENT PROGRAM: STATE MATCH FUNDING APPLICATION** | | | | | | | | | |
| 1. Applicant Agency | | | 2. CARS Agency Number | | | | | | |
| Street Address | | City | | | | State | | | Zip |
| Mailing Address | | City | | | | State | | | Zip |
| 5. Name of Program Director and Title | | | | | 6. Phone Number with Area Code | | | | |
| 7. Name of Business Manager and Title | | | | | 8. Phone Number with Area Code | | | | |
| 9. Contact Person for Application | | | | | 10. Phone Number with Area Code | | | | |
| 11. Type of Agency (Public or Private Non-Profit) | | | | | 12. County | | | | |
| 13. Geographic Service Area (List Counties and Tribes Served) | | | | | | | | | |
| 14. Dates of Federal Program Period Award (mm/dd/yy – mm/dd/yy)       – | | | | | | | | | |
| 15. Number of VSY’s awarded: | 16. Estimated number of: Volunteers:       Sites: | | | | | | | | |
| 17. Name – Authorized Submitter (*Print or Type)* | | | | | | | | | |
| **SIGNATURE** – Authorized Submitter *(Full Signature)* | | | | | | | | Date Signed | |
| Summary Budget | | | | NOTE: Please Use Whole Dollar Amounts | | | | | |
| Source of Funds | | | | Total Costs | | | | | |
| a. Federal Funds | | | |  | | | | | |
| b. State FGP Match Funds Requested | | | |  | | | | | |
| c. Other State Funds | | | |  | | | | | |
| d. Local Funds Including In-Kind | | | |  | | | | | |
| e. TOTAL BUDGET | | | | $ | | | | | |
| f. Percent | | | | % | | | | | |
| Submit to:  ATTN: Foster Grandparent Program  Division of Public Health  PO Box 2659  Madison WI 53701-2659  [dhsdphaging@wisconsin.gov](mailto:dhsdphaging@wisconsin.gov) | | | | | | | | | |