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| **Name of Applicant Organization and Address** | | | | | | | | **Application Organization Contact**  **Name:**  **Phone:**  **Email:** | | | | | | |
| **SBHC Medical Sponsoring Agency Contact**  **Name:**  **Phone:**  **Email:** | | | | | | | |  | | | | | | |
|  | | | | | |  |  |  | | | | | | |
| **General Information Status** | | | | | |  |  | **Funding Amount**: For each SBHC, please indicate the estimated amount of funding support provided from each source.  If In-Kind support, please indicate “In-Kind”. (Check all that apply) | | | | | | |
| Name of School | Address of School | Continuing Application (Renewal) | SBHC Program  Closed/ Discon-tinued  Date | Projected NEW SBHC 2022  (Yes or No) | Traditional  SBHC | Tele-health SBHC | Level  of Service  (I ,II,or III) | State | Local | Other Health Provider | Other State Funds | Private donors/Org. | Federal Funds | Other |
| 1. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 4. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 6. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- |
| **Services to be supported by the requested grant funds (check all that apply):**  □ Primary care/Medical □ Oral Health □ Mental Health □ Health Education □ Nutrition □ Administration/support staff □ Equipment/Supplies □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Project Summary (100 words or less):** |

**🞏 The local superintendent has been notified and made aware of the SBHC Program application for Fiscal Year 2022.**

**(not required for telehealth added to an existing SBHC)**

**Local Superintendent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Additional Comments/Notes:** |

# Addendum for additional sites

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| **General Information Status** | | | | | |  |  | **Funding Amount**: For each SBHC, please indicate the estimated amount of funding support provided from each source.  If In-Kind support, please indicate “In-Kind”. (Check all that apply) | | | | | | |
| Name of School | Address of School | Continuing Application (Renewal) | SBHC Program  Closed/ Discontinued  Date | Projected NEW SBHC 2021  (Yes or No) | Traditional  SBHC | Tele-health  SBHC | Level  of Service  (I ,II,or III) | State | Local | Other Health Provider | Other State Funds | Private donors/Org. | Federal Funds | Other |
| 9. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |