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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-tinuedDate | Projected NEW SBHC 2022(Yes or No) | Traditional SBHC | Tele-health SBHC | Levelof 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/ DiscontinuedDate | Projected NEW SBHC 2021(Yes or No) | Traditional SBHC | Tele-healthSBHC | Levelof Service (I ,II,or III) | State | Local | Other Health Provider | Other State Funds | Private donors/Org. | Federal Funds | Other |
| 9.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 13. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |