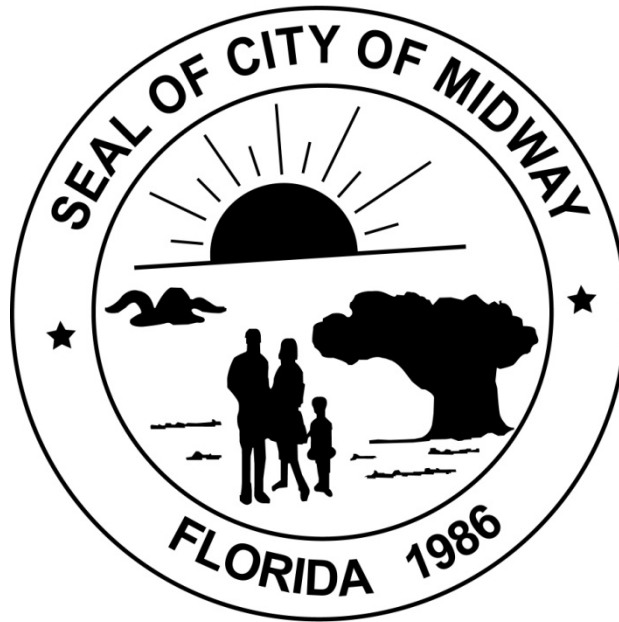


CITY OF MIDWAY NON-PROFIT PARTNERSHIP



2010/2011

CITY/COUNTY APPLICATION

AND

INSTRUCTIONS

**SERVING THE PEOPLE OF
THE CITY OF MIDWAY, FL**

INSTRUCTIONS FOR SUBMISSION OF REQUEST PACKET

All information presented in Form 1 through 7 should be based on this fiscal year unless otherwise noted. Failure to include information in Form 6 will result in your program being excluded from this year's funding cycle. If you do not have the information requested but you have applied for it, please indicate which agency and the time frame that you expect to receive it. Attach all necessary documentation as proof.

Ten (10) bound, collated, three-whole punched funding applications (including original) for each program that you are requesting funds for. Applications should be submitted to City of Midway Non-Profit Partnership (CMNPP) no later than 5:00p.m. on Friday, August 20, 2010. Each application must include the following:

1. **FORM 1** 2010/2011 Request Cover Sheet
2. **FORM 2** Composition Overview Grid - Clients, Board and Staff
3. **FORM 2B** Organizational Representation
4. **FORM 3** Organizational Mission, Goal & Objectives
5. **FORM 4** Fundraising Plans
6. **FORM 5** Budget Worksheet
7. **FORM 6** Legal Requirements
8. **FORM 7** Program Summary

Return packet to:

Rosilyn Copeland
Administrative Services Director
City of Midway
P.O. Box 438
Midway, FL 32343
Office: (850) 574-235

INSTRUCTIONS FOR FORMS 1-7

Form 1 **2010/2011 Request Cover Sheet**

This form should include agency contact information, the legal (corporate) name of the agency, agency director (s), and the fiscal year in which you are applying (i.e. FY 2010/2011) and the amount of funding requested. **Cover letters should be typed on agency letterhead.**

Form 2 **Composition Overview Grid - Clients, Board and Staff**

List the agency's clients, Board of Directors and professional and support staff composition.

Form 2B **Organizational Representation**

List the agency's Board members and officers and the areas in which they work.

Form 3 **Organizational Overview**

(THREE (3) PAGE LIMIT , Double-space, 1 inch margins, use Times New Roman size 12 font. Failure to submit in proper format will cause your application to be rejected.)

Provide a clear, concise overview of the organization, purpose and reason for and amount of the funding request. Be sure to show how your proposal furthers the City of Midway Non-Profit Partnership's mission, goals and matches the CMNPP grant application guidelines.

1. Define the problem that your agency addresses. 2. Can the problem be measured? If so, how?
3. Is the problem getting better or worse? 4. How is your agency influencing the outcomes? 5. If your agency is having a positive impact on the problem, show how. 6. If the problem continues to worsen, describe some things that your agency could do with more staff, more funding, etc. to make a greater positive impact on the problem. 7. List some things that you may or may not have done in the past that can be done to maintain the problem until more funding is available.
8. List the overall mission of the agency (mission statement). Identify goals and objectives accomplished during the previous fiscal year and the current fiscal year.
9. Lastly, identify goal and objectives your agency plans to accomplish during the upcoming fiscal year and list agency partnership/community collaborations. Such agreements provide structure, stability, and commitment to the ongoing work of your agency.

Form 4 **Fundraising Plans**

Identify agency fundraising plans such as sponsorships and other various activities to generate funds to support the agency and its program delivery outside of funding granted in this process. Please do not list format grants or in-kind donations.

Form 5 **Budget Worksheet**

The form represents the total agency budget. Use one form 5 for each year designated (2009/2010) represents the previous year's funding, (2010/2011) represents the current year, and (2010/2011) represents the projected budget. All budgets will be reviewed by the Partnership Review Panel.

Form 6 **Legal Requirements**

Answer the questions and attach all documentation to show that your agency is legally recognized to operate in the state of Florida.

Form 7 **PROGRAM SUMMARY INSTRUCTIONS**

GENERAL INSTRUCTIONS

SECTION 1, Part C-Client Composition

This section is really important because the review board wants to see the number of clients served by year and the board also likes to compare the number of clients served in each city throughout Gadsden County. Please make sure your numbers are accurate by year and by county. Be prepared to justify the number of clients served over time.

This form is designed to provide agencies with a format in which to present all essential information relevant to a specific program.

Please prepare form carefully and persuasively. It is very important in your funding request.

Section 1 is intended to give reviewers a feel for the size and scope of a program. Specific data such as resources necessary for service provision, numbers of clients served and cost per client and unit of service will give an overall picture of the program and sets the stage for Section 2. **SECTION 2** asks for specific, program-related information which is intended to give reviewers data to make informed funding decision. This information will also be incorporated into future CMNPP fundraising campaigns as tools to strengthen the case for giving.

To calculate program costs by clients, use the following calculation:

program expenditure divided by total program clients = cost per client served

This information will be used by the review board for comparison purposes (the program's efficiency over a period of time, as compared to similar programs seeking CMNPP funding, etc.). Make certain that the data used agrees with the data submitted on your budget forms.

While cost per client calculation is simple, it is recognized that it may not be the best measure of program efficiency. Consequently, you have the opportunity to use another measure of efficiency for your program. This is supplemental to, not in lieu of, the cost per client served. For instance, you might choose to show the cost per service in conjunction with a measure of average service hours per client to demonstrate a program's efficiency.

In such a case, the formulas you would use would probably be as follows:

program expenditures divided by program service hours = cost per service hour
program service hours divided by total program clients = cost per service hour

Form 2

Please complete the following grid (one for each year and each program) concerning the composition of your consumers, current staff and Board of Directors as of the end of the fiscal year 2008-2009 and 2009/2010.

FY 2008/09	A Client Composition (Number)	B Board of Directors (Number)	C Program/ Professional Staff (FTE)	D Support Staff (FTE)	E Total Staff (FTE)
BY RACE:					
1. Caucasian					
2. African American					
3. American Indian or Alaskan Native					
4. Hispanic					
5. Asian or Pacific Islander					
6. Other					
7. TOTAL:					
BY GENDER:					
8. Male					
9. Female					
10. TOTAL:					
BY AGE:					
11. Birth-5					
12. 6-12					
13. 13-18					
14. 19-25					
15. 26-39					
16. 40-54					
17. 55 and above					
18. TOTAL:					
19. No. of Persons With Disabilities					
BY RESIDENCE:					
20. Midway					
21. Havana					
22. Quincy					
23. Gretna					
24. Greensboro					
25. Chattahoochee					
26. Others					
27. TOTAL:					

Form 2

Please complete the following grid (one for each year and each program) concerning the composition of your consumers, current staff and Board of Directors as of the end of the fiscal year 2008-2009 and 2009/2010.

FY 2008/09	A Client Composition (Number)	B Board of Directors (Number)	C Program/ Professional Staff (FTE)	D Support Staff (FTE)	E Total Staff (FTE)
BY RACE:					
1. Caucasian					
2. African American					
3. American Indian or Alaskan Native					
4. Hispanic					
5. Asian or Pacific Islander					
6. Other					
7. TOTAL:					
BY GENDER:					
8. Male					
9. Female					
10. TOTAL:					
BY AGE:					
11. Birth-5					
12. 6-12					
13. 13-18					
14. 19-25					
15. 26-39					
16. 40-54					
17. 55 and above					
18. TOTAL:					
19. No. of Persons With Disabilities					
BY RESIDENCE:					
20. Midway					
21. Havana					
22. Quincy					
23. Gretna					
24. Greensboro					
25. Chattahoochee					
26. Others					
27. TOTAL:					

FORM 4 FUNDRAISING PLANS

Outline 2010/2011 fundraising plans.

EVENT	DATE	Possible Dollar Results or Specific Results if the Event has Been Completed

PROJECTED TOTALS: \$ _____

FORM 5

BUDGET WORKSHEET: What are the programs cost?

<u>Column A</u> Budget Category	<u>Column B</u> Budget Computation	<u>Column C</u> Other Contributions/Funding Agency	<u>Column D</u> Total Cost
Example: Training/Seminars	\$212.50 X 2 people x 2 trips	\$250/United Way	\$850.00
Personal (Salaries & Benefits)			
Contracted Staff/Services			
Equipment (\$500 or more)			
Property (\$499 or less)			
Materials & Supplies			
Publications			
Postage			
Rent			
Telephone			
Utilities			
Training/Seminars			
Staff Travel			
Contributions/Special Events			
Dues/Membership Fees			
Program Service Fees			
Misc. Other Expenses (List Below)			
TOTAL:			

FORM 6

LEGAL REQUIREMENTS

The following are the minimum legal requirements of the CMNPP. An agency must meet these criteria to qualify for funding.

1. Registration with the U.S Department of Treasury, Section 501 C (3), Internal Revenue Service Code, for exempt status. Tax Exempt # _____

2. Registration with the Florida Department of Agriculture and Consumer Services, pursuant to chapter 496. F.S. Registration # _____
 - If your organization is exempt, as provided for in section 496.406, F.S., a copy of your exemption letter must be attached to this application.

 - If your organization is automatically excluded, pursuant to section 496.403, F.S., check

3. Your organization must be registered as a non-profit corporation with the Florida Department of State pursuant to chapter 617. F.S. Registration # _____

4. If your organization has a physical presence in Florida, you must be registered with the Florida Department of Revenue pursuant to Chapter 212.08. F.S. State Sales Tax Exempt # _____

FORM 7

PROGRAM SUMMARY

(Complete Form 7 for each program for which you are requesting funding from CMNPP).

AGENCY NAME: _____

PROGRAM NAME: _____

PROGRAM SERVICE: _____

SECTION 1: PROGRAM DATA

A. PROGRAM FUNDING

ALLOCATION 2009/2010		REQUEST 2010/2011	
MIDWAY	\$ _____	MIDWAY	\$ _____
HAVANA	\$ _____	HAVANA	\$ _____
QUINCY	\$ _____	QUINCY	\$ _____
GRETNA	\$ _____	GRETNA	\$ _____
GREENSBORO	\$ _____	GREENSBORO	\$ _____
CHATTAHOOCHEE	\$ _____	CHATTACHOOCHEE	\$ _____

B. PROGRAM RESOURCES

PROGRAM RESOURCES INPUT	2008/09 Previous	2009/10 Current	2010/11 Proposed
Total program Budget	\$ _____	\$ _____	\$ _____
Program Staff (FTE)	\$ _____	\$ _____	\$ _____
Program Volunteers value \$14hr	\$ _____	\$ _____	\$ _____
Program In-Kind Donations	\$ _____	\$ _____	\$ _____

C. PROGRAM CLIENT COMPOSITION

CITY	2008/09 Served	2009/10 Served	2010/11 Estimate
Midway			
Havana			
Quincy			
Gretna			
Greensboro			
Chattahoochee			
All Others			
TOTAL:			

D. PROGRAM COSTS

1. Cost Per Client \$ _____ 2. Cost Per Unit of Service \$ _____ *

*Describe Unit of Service

E. TARGETED NEIGHBORHOODS AND PERCENTAGE OF CLIENTS SERVED IN EACH

Neighborhood % served		
1. Midway _____	2. Havana _____	3. Gretna _____
4. Quincy _____	5. Greensboro _____	6. Chattahoochee _____

FORM 7 (CONT'D)

SECTION II. PROGRAM DESCRIPTION

A. Narrative Description of Program:

Succinctly describe program, including types of services provided, how and by whom (staff, volunteers, etc.) they are provided, and any fees or eligibility requirements for clients.

B. Documentation of Need:

Justify the need for this program and why it should be funded by CMNPP. If available, provide avoided cost data (costs which can be avoided if your program successfully intervenes) or other measures of savings attributable to your program. All data sources relied upon should be noted.

FORM 7 (CONT'D)

C. Target Population:

Please define identified population this program is intended to serve. Please include the actual or estimated number of those identified.

D. Unmet Needs:

Many factors beyond an agency's control can influence the numbers of eligible clients served and unserved. What factors account for the unmet needs in this program?

FORM 7 (CONT'D)

E. Outreach

What methods are used to reach this program's target population?

F. Justification of Program Delivery Structure:

Explain why the program delivery structure chosen for this program is preferable to any possible alternatives.

G. Collaboration:

Address your efforts to work with other agencies to increase your productivity in providing services and to improve the scope and quality of services provided to your clients.

FORM 7 (CONT'D)

H. Program Impact:

Address the impact your program has on clients served and the community as a whole (Any quantification you can provide would be helpful. Treat this as an additional opportunity to justify your program.

1. Population Served

2. Community