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| affiliate-ID-align-right-300px**Columbus County Partnership for Children** 109 West Main Street Whiteville, NC 28472Phone: (910) 642-8226 Fax: (910)642-8494<https://columbussmartstart.com>  |
| **Application for Smart Start Funding****2024-2025** |
| **APPLICANT DATA:** |
| Organization Name: | Columbus County Partnership for Children – Smart Start |
| Mailing Address: | 109 W. Main Street |
| City: | Whiteville | State: | NC | Zip: | 28472 | County: | Columbus |
| Federal Tax ID #: | 56-1966108 |
| Contact Person Name: | Charmaine Blue-Singletary |
| Contact Person Title: | Program Coordinator |
| Address (if different): | 109 W. Main Street |
| City: | Whiteville | State: | NC | Zip: | 28472 | County: | Columbus |
| Telephone (incl area code): | 910-499-4545 | Fax: | 910-642-8494 |
| E-mail address: | Charmaine.bluesingletary@columbussmartstart.org |
|  |  |
| **AGENCY DATA:** |
|  | Private, Non-Profit 501©(3) Corporation |  | For Profit Business |
|  | Public Agency (Co., State, Fed.) |  | Other (Please specify) |
|  |  |  |  |
| Has this organization received Smart Start funds in the past? |  | Yes |  | No |
| If yes, from which Partnership(s) and when? |  |
| **ACTIVITY INFORMATION:** |
| Activity Name: |  | Funds Requested: | $ |
| Do you expect to **continuation funds** from Smart Start in the future? |  | Yes |  | No |
|  |  |
| I certify that all information on this application is true and correct to the best of my knowledge. |
|  |
| Authorized Agency Representative: |  |
|  | (name & title) |
| Date:  |  |
|  |

Attachment I

***Section B: Limit responses to the following questions to a total of 5 pages.***

*Paste desired Contract Activity Description Here.*

To complete the application, provide a comprehensive narrative response to the **Scope of Work** and the questions in the following sections:

**1. Capacity for Addressing the Needs and Implementing the Strategy**

* Provide examples of experience implementing related programs and the outcomes of those programs. It should be noted that past performance on any grants may be taken into consideration in the evaluation of your proposal.
* Describe your agency/organization’s personnel, professional knowledge of, and experience in working with the target population, especially for those personnel who will work directly with the grant activities.
* Identify how qualified personnel will be selected and supervised.
* Describe plans for ensuring personnel will be linguistically and culturally competent to work with the target population.

**2. Program Description**

* Describe the proposed program.
* What evidence do you have to demonstrate that the program is evidence based/evidence informed?
* Identify and describe the target population to be served
	+ Population demographics
	+ Target service numbers
	+ How the population will be identified, recruited, and retained in the program.
* Describe any anticipated barriers to implementation and your plans to overcome those barriers.
* List the anticipated collaboration partners and how each of these collaborations is important to the successful promotion of the Smart Start network and implementation of the program.

**3. Implementation Plan**

* Provide a proposed timeline for implementation of your program.
* Include a brief narrative describing the steps necessary to operationalize the proposed program, including any required components for model fidelity or to meet program requirements.
* Describe the evaluation plan for assessing program effectiveness.

**Budget and Budget Narrative**

Submit a budget and budget narrative as part of this application. Use the detailed Budget Workbook document included in this packet.

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| Organization Name:  |
| Grant Period: July 1, 2024 through June 30, 2025 |
|  |  |  |  |
|   |   | **2024 - 2025** |  |
|  |  |  | **Budget Narrative** |
| **Expenditure Categories** |  | **Budget** |  |
|   |   |   |  |
| Salaries and Wages |   | 0.00  |  |
| Fringe Benefits |   | 0.00  |  |
| **Total Wages and Fringe Benefits** | **0.00**  |  |
|   |   |   |  |
| Office Supplies and Materials  |   | 0.00  |  |
| Program Supplies and Materials | 0.00  |  |
| Travel  | 0.00  |  |
| Meeting/Conference Expense  |   | 0.00  |  |
| Employee Training (no travel)  |   | 0.00  |  |
| Subcontracted Services |   | 0.00  |  |
| Other: |   | 0.00  |  |
| Other:  |   | 0.00  |  |
| Other:  |   | 0.00  |  |
|   |   | 0.00  |  |
| **Total Programmatic Expenses** | **0.00**  |  |
|   |   |   |  |
| Administrative Costs |   | 0.00  |  |
| **Total Indirect/Administrative Costs (No more than 8%)** | **0.00**  |  |
|   |   |   |  |
| **Totals** |  | **0.00**  |  |
|  |  |  |

 Attachment II

Attachment III