APPLICANT'S PROPOSAL CHECKLIST

DIRECTIONS: Review your proposal by using the check list. All items must be completed correctly in order for the proposal to be approved by the Region and the State. **PLEASE SIGN ON THE LAST PAGE AND RETURN THE COMPETED CHECK LIST WITH THE PROPOSAL.**

Internal use only A	Check if complete B	ITEM	
	SECTION I: APPLICANT/AGENCY INFORMATION		
		A-I	Self-explanatory (note any missing information)
		J	Proposed funding period complies with the time frame of regional planning (July 1, 2006 through December 31, 2008)
		K	Proposed number of families and/or children and/or clients to be served are clearly stated
		L	Check whether your program serves individual clients or families
		M	Total amount of funds requested clearly stated
		N	Total amount requested with breakdown by Region
		O	Signature/title of applicant's agent - signed (not typed) **in blue ink**
		P	Date submitted to Department of Child Services
	SECTION II: ASSURANCES		
			Assurances - Must be signed by person who signed **(in blue ink)** in Section I, Item O
	SECTION III: BUDGET SUMMARY AND BUDGET JUSTIFICATION WORKSHEETS		
			Documentation of cost calculations must be shown on the Budget Justification Worksheets; verify calculations)
			A- Personnel (1. Salaries & Wages; 2. Fringe Benefits)
		A	Position/Job Title for all staff and supervisor positions
		B	Service-service abbreviation is listed
		C	Number of hours each position is employed and number of hours spent face-to-face with clients/families is identified
		D-F	Salaries and wages for the program are listed by position
		G-H	Fringe Benefits are properly calculated
			3. Consultant and Contract Services
		A-F	Contract Position – all contract positions are noted
			B - Budget Justification Worksheet-Other Direct Costs
		1	Travel expenses (max. $.40 per mile): staff and/or clients
		2	Consumable supplies and printing
		3	Space costs: rent and/or utilities and/or custodial
		4	Insurance
		5	Staff training
		6	Telephone and postage
		7	Rental/lease/purchase of equipment
		8	Other administrative expenses
		9	Other direct costs
			C - Budget Justification Worksheet-Indirect Costs
		1	Accounting services
		2	Other
			D - Inkind Contributions and Other Grants/Income
			Inkind contributions and other grants/income listed by county
	SECTION IV: SERVICE UNIT RATE JUSTIFICATION AND DEFINITION/COST ANALYSIS		
		1	Total adjusted program costs
		2	Total number of Families or Clients to be served
		3	Average amount of funds per Family or Client
		4	Define each billable service unit and rate **as defined in the Program Service Standards** – total of units multiplied by the unit rates should be equal to the total adjusted program costs (or close).
	SECTION V: REGIONAL REQUEST SUMMARY (complete a separate page for each Region to be served)		
		A-D	Self explanatory
		E	Breakdown of proposed services by county, including type of service, number of families or Clients, and public funds requested by county.

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	SECTION VI. PROGRAM NARRATIVE AND REQUIRED STATEMENTS		
		A	Problem/Needs Statement - the needs have been described and the problems to be addressed by the program have been stated
		B	Target Population - has been checked for appropriateness for the intent of the program/ Service
		C	Program Objectives and Evaluation
		1	Objectives are measurable, have proposed outcomes stated, and include and are compatible with the overall objectives for the funding as indicated in the program service standards
		2	Provider has agreed to complete the required service provider reports and evaluations
		D	Program Description/Service Delivery Methods
		1	Tasks/activities for achievement of objectives and persons responsible for completion of tasks are clearly described
			Proposed client system, client referral, and client eligilbity requirements are clearly stated. Hours of service deliver convenient and flexible (must be specifically stated for Homemaker, Intensive Family Preservation Service Worker, Parent Aid, and Home Based therapy standards) proposed time period between referral of client and initial service contact clearly stated.
		3	Program activities in which clients will participate and/or services they will receive
		4	Client case record and program statistical data collection. Method of providing plans/reports/documentation to referring local DCS clearly described. Specify that client specific goals/objectives are clearly stated and shared with the client. Procedures for maintaining client confidentiality clearly stated.
		5	For services that have not been standardized, a copy of the instructions to be given to staff outlining the standards they are to use when determining if a billable service has been performed is attached.
		E	Cultural Diversity and Competency of Staff
		1	Upgrade and maintain cultural knowledge base of staff regarding issues of diversity and cultural competence, particularly with primary populations being served
		2	Description of the engagement and assessment process of the client regarding strengths, goals and self identity
		F	Staffing
		1	Job descriptions and qualifications of personnel assigned to the program are attached
		2	An organizational chart is attached
		3	Any staff positions newly funded under this proposal are identified
		4	Your planned staff development activities' schedule for the program during the year is described
		G	Agency/Applicant's Background, Facilities, Community Relationships -Includes statement(s) regarding routine agency and staff performance evaluation processes (include performance appraisal forms). -Includes statement(s) regarding agency's services accessibility and geographical convenience; appropriateness of environment, equipment, service hours, office space, and facility maintenance. -Includes statement(s) regarding agency's formal and informal relationships with other agencies. -Includes statement(s) regarding agency's history of working with the local DCSs, acknowledging overall service coordination is responsibility of local DCS and that any agency treatment activity, therapy, and service plan for a specific client/family will be consistent and compatible with the DCS Case Plan, Informal Adjustment, or Service Referral Agreement.
		H	Program Affiliations – Includes statement(s) regarding agency's qualifications and current licenses, accreditations, affiliations, certifications, etc., pertinent to providing this program.

Internal use only	Check if complete	ITEM	
		SECTION VII: ATTACHMENTS	
		I	Direct Deposit Form
		J	State of Indiana W-9
		K	FSSA Provider Data Form
		L	Minority Business/Women Business Participation Agreement

To my knowledge, the proposal has all of the required components. I understand that I may be asked to provide additional information. If so, I understand that I will be contacted by fax and I will have 5 days to respond with missing or corrected information.

Program Title/Service

Applicant/Agency Name

Signature of Applicant's Agent **Date**