Sutter County Medi-Cal Collaborative Funding Application

Applicant Name: Title: Date:

Email: School Site: Phone Number:

OVERVIEW OF THE PROPOSAL

Describe your request for funding from the MediCal collaborative

PURPOSE OF THE FUNDING

Describe how this proposal will meet this un-met need and supplement existing services.

How many students/families to you estimate will directly benefit and for how long?

Describe the administrative support for this proposal.

TRAINING

"Complete this section if proposal is to provide and/or host training."

Describe the intended audience and size.

Describe the trainer qualifications.

Describe the research basis of the training.

BUDGET

Object	Amount	Description
(1000-1999: Certificated Salaries)	$	
(2000-2999: Classified Salaries)	$	
(3000-3999: Employee Benefits)*	$	
(4000-4999: Books & Supplies)	$	
(5000-5999: Services, Training)	$	
(6000-6999: Equipment)**	$	
(7000-7999: Indirect		
TOTAL ESTIMATED BUDGET	$	

*The cost of statutory benefits must be included (3000-3999: Employee Benefits) when salaries are paid.

SIGNATURES

By signing this form, you confirm that you and your administrator have discussed this proposal and understand that you are responsible for implementing the proposal as outlined if this proposal is funded.

Applicant's Signature *Date*

CBO/Accountant's Signature *Date*

Director/Superintendent's Signature *Date*