

Contact Information		
Date		
Agency Name		
Agency Mailing Address		
Agency Contact Representative		
Contact Telephone Number		
Contact Email Address		
Indicate current services, DBHDS license and DMAS participation agreement or professional required credentials (submit copy of these documents with application, if applicable)		
Current program(s)	DBHDS license type (if applicable) or professional credentials	DMAS participation agreement number
Planned Services		
Describe provider's history in providing DD waiver services in Virginia or another state		
Indicate if funding will result in the addition of new services and/or expanded services and the number of people who will be supported in this proposed program	New service(s) or expanded service(s) option and the number of people to be served. <input type="checkbox"/> New Service <input type="checkbox"/> Expanded Service	
Enter the-cities/counties where services will be provided because of Jump-Start funding	Please review the Provider Data Summary Baseline Measurement Tool at DBHDS.virginia.gov	
	Enter Cities/Counties	Enter Service(s)
Indicate the services you are planning to offer with Jump-Start Funding. Funds may be requested up to the indicated amounts. (Check no more than two services)	<input type="checkbox"/> Behavioral Therapeutic Consultation (\$15,000) <input type="checkbox"/> Benefits Planning (\$10,000) <input type="checkbox"/> Combined Community Coaching and Community Engagement (\$40,000) <input type="checkbox"/> Community Coaching (\$25,000) <input type="checkbox"/> Community Engagement (\$25,000) <input type="checkbox"/> Community Guide (\$15,000) <input type="checkbox"/> Electronic Home-Based Services (\$10,000) <input type="checkbox"/> Employment and Community Transportation (\$25,000) <input type="checkbox"/> Independent Living Supports (\$25,000) <input type="checkbox"/> In-Home Supports (\$25,000) <input type="checkbox"/> Peer Mentoring (\$10,000) <input type="checkbox"/> Private Duty Nursing (\$25,000) <input type="checkbox"/> Shared Living (\$10,000) <input type="checkbox"/> Skilled Nursing (\$25,000) <input type="checkbox"/> Sponsored Residential- Children (\$10,000 per individual) <input type="checkbox"/> Supported Living (\$25,000)	

Funding Request			
Category	Description	Service	Total for this request
Statement of Individual Benefit			
Describe how the individuals identified will benefit from these purchases.			
Statement of Sustainability			
Describe how the provider will sustain service provision beyond receipt of Jump-Start funding.			
Signatures			
Provider agrees to participate in a DBHDS program review upon request: <input type="checkbox"/> Yes <input type="checkbox"/> No Provider agrees to share program accomplishments upon request for two years from approval date: <input type="checkbox"/> Yes <input type="checkbox"/> No This application is submitted for consideration by: Agency's Name: _____			
_____	_____	_____	
Print name /Title	Signature	Date signed	
Received by:			
_____	_____	_____	
DBHDS representative	Signature	Date signed/received	
Submit the completed application, copy of license (if applicable), participation agreement, Jump-Start Acknowledgement & Assignment of Award form(s) (must be received before funds are distributed; minimum of three individuals), and program budget by email to: jumpstart@dbhds.virginia.gov			

Additional information for describing Planned Services or Statement of Sustainability.