FIREFIGHTER BEHAVIORAL HEALTH ALLIANCE

GRANT APPLICATION FOR FIRE DEPARTMENT TRAINING FOR 2018

ORGANIZATION CONTACT INFORMATION

Name		
Title/Rank		
Phone | Fax		
E-mail		

ORGANIZATION INFORMATION

Name of Organization			
Address			
City, State, Zip Code			
Phone			
Fax			
Website			
Type of members	Career	Combination	Volunteer/POC
Number of Members on Department	FT	PT	Volunteer/POC

PROGRAM REQUEST

Current Annual Operating Budget		2018	
Current Annual Training Budget		2018	
Program Provided	Saving Those Who Save Others – 4hr Workshop OR Internal Size Up – 4hr		☐ ☐
Anticipated Date of Workshop		2018	Month
Are you open to offering this workshop to nearby departments?			
Will you actively promote attendance for this workshop?			
Has your organization been directly affected by suicide?			
Do you have a Peer Support Program?			

Please provide a paragraph of your department's need or desire for this workshop:

AGREEMENT

1. All information disclosed in this document will be kept confidential.
2. All Grant funds are offered through Firefighter Behavioral Health Alliance.
3. By submitting this application, you certify that all of the information is correct. You agree to abide by the requirements listed below:

- Class should have a minimum of 30 attendees, unless approved otherwise.
- If class is cancelled three weeks prior to scheduled date, the department is responsible for all non-refundable travel expenses incurred.
- If your department wants additional training, the department is responsible for the costs of those additional workshops and any expenses for extending the engagement.
- Department is responsible for refreshments, lunch, etc. during the workshop if applicable.
- In order to be considered for this Grant, you must submit 2017 financial statements as follows: Profit & Loss(Income Statement) and Balance Sheet.

4. By submitting this application, you authorize FIREFIGHTER BEHAVIORAL HEALTH ALLIANCE to review this application and its contents to determine need.

SIGNATURES

Signature of Authorized Personnel		Signature of Department Chief if not the Authorized Personnel	
Name and Title		Name and Title	
Date		Date	

OFFICIAL USE ONLY

Date Received:	Approved:	Denied:	Reason: