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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01999B (09/2019) |  | **STATE OF WISCONSIN** |
| **SENIOR COMPANION PROGRAM: STATE MATCH FUNDING APPLICATION** |
| 1. Applicant Agency      | 2. CARS Agency Number      |
| Street Address      | City      | State      | Zip      |
| Mailing Address      | City      | State      | Zip      |
| 5. Name of Program Director and Title       | 6. Phone Number with Area Code       |
| 7. Name of Business Manager and Title       | 8. Phone Number with Area Code       |
| 9. Contact Person for Application       | 10. Phone Number with Area Code       |
| 11. Type of Agency (Public or Private Non-Profit)       | 12. County       |
| 13. Geographic Service Area (List Counties and Tribes Served)       |
| 14. Dates of Federal Program Period Award (mm/dd/yy – mm/dd/yy)       –       |
| 15. Number of VSY’s awarded:       | 16. Estimated number of: Volunteers:       Sites:       |
| 17. Name – Authorized Submitter (*Print or Type)*       |
| **SIGNATURE** – Authorized Submitter *(Full Signature)* | Date Signed |
| Summary Budget | NOTE: Please Use Whole Dollar Amounts |
| Source of Funds | Total Costs |
| a. Federal Funds |       |
| b. State SCP Match Funds Requested |       |
| c. Other State Funds |       |
| d. Local Funds Including In-Kind |       |
| e. TOTAL BUDGET | $      |
| f. Percent |      % |
| Submit to:ATTN: Senior Companion ProgramDivision of Public HealthPO Box 2659Madison WI 53701-2659dhsdphaging@wisconsin.gov |