

***New York State Association  
of Day Service Providers  
2010***

**THE MARY FRAWLEY MEMORIAL GRANT APPLICATION**

(Please Print Information Below)

Agency Name & Program Name: \_\_\_\_\_

Type of Program: Day Treatment, Day Habilitation, Pre-Vocational, SEMP or OPTS  
(circle one)

Program Address: \_\_\_\_\_

Applicant Name/Title: \_\_\_\_\_

Applicant Telephone: (include area code) \_\_\_\_\_

Applicant Fax: \_\_\_\_\_

Applicant E-mail address: \_\_\_\_\_

Supervisor Name: (name of person supporting this project): \_\_\_\_\_

Supervisor Address: \_\_\_\_\_

Supervisor E-Mail \_\_\_\_\_

NYSADSP Region : Central East, Central West, West, Long Island, NYC, Southeast  
(Circle One)

TITLE OF GRANT : \_\_\_\_\_

DATE OF APPLICATION: \_\_\_\_\_

**Since this space is limited, you may attach additional pages to give thorough explanations, if you are attaching pictures or samples, you must include 6 samples of each so that all committee members can review, otherwise, these samples will not be reviewed with application. DO NOT send 6 copies of this application- only one application.**

1. Has this project already begun implementation? Yes or No

- If yes, note the implementation date \_\_\_\_\_.
- If yes, note how this grant will assist in your efforts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe the proposed project, including the key features of the project, the results that are expected and why you feel this project should be awarded to your program.

\_\_\_\_\_  
\_\_\_\_\_

3. Describe how the project will provide;

- Community Inclusion or Relationship Building:

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- Consumer Participation

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- Applicability to other day programs

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- Community Awareness

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4. Describe the cost of the project and agency commitment (funds, equipment, matching funds, administrative support, itemized expenditures for requested funds) **Note : grant monies will not be awarded to cover staffing costs.**

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5. How much are you requesting in grant monies? \_\_\_\_\_  
 If the total requested amount can not be approved, will you accept a reduced amount?  
 Yes \_\_\_\_\_ No \_\_\_\_\_ Comments : \_\_\_\_\_

6. Describe the originality of this project. How was it developed? Where did the idea originate, what research went into this request?

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7. Describe how this project will be sustained by your agency after the use of the grant monies.

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Applicant Signature	Date
Executive Directors Signature	Date

Mail, Fax or E-Mail Application to: Lynn M. Goodwin  
 NYSADSP  
 60 East Market Street #200  
 Corning, NY 14830  
 Fax: (607) 937-3203  
 Phone: (607) 937-3221  
 E-Mail: [lgoodwin@pathwaysforyou.org](mailto:lgoodwin@pathwaysforyou.org) \* If e-mailed, you must fax or mail signature page for approvals (unless scanned and e-mailed)

**All applications must be received no later than Wednesday, March 17, 2010 to be considered.**