**School Health Professional Grant Program**

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| **Part I: Cover Page** *(Complete and attach as the first page of proposal)**\*Applications will not be accepted from individual schools or Charter schools* |
| **Name of Education Provider:**  |  |
| Mailing Address:  |
| **Authorized Representative:**  |  |
| Telephone:  | Fax:  |
| Email:  | District Code: | DUNS #: |
| **Signature:**  |
| **Program Contact Person:** |  |
| Telephone:  | Fax:  |
| Email:  |
| **Signature:**  |
| **Fiscal Manager:** |  |
| Mailing Address:  |
| Telephone:  | Fax:  |
| Email:  |
| **Type of Education Provider:** *Check one box below that best describes your organization.* |
| [ ]  | School District  | [ ]  | Board of Cooperative Educational Services (BOCES) |  | [ ]  | Charter School Institute |
| **Region:** *Indicate the region(s) this proposal will directly impact* |
| **□ Metro □ Pikes Peak □ North Central □ Northwest □ West Central****□ Southwest □ Southeast □ Northeast** |
| **Recipient Schools:** *Indicate the intended recipient schools (additional rows may be added). Please list all schools impacted by this funding* |
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| **Grant Information*****The following information will be verified by CDE and considered in the funding decision:*** |
| **Amount Requested:** *Indicate the total amount of funding you are requesting for this grant***.**  |
| **Year 1 (2015-2016): $** |
| **Amount to Match:** *Indicate the total amount of funding you will match for this grant.* |
| **Year 1 (2015-2016): $** |
| **Are legal retail marijuana sales allowed in education provider’s city/county?** | **Yes** [ ]  **No** [ ]  |
| **Number of retail/medical marijuana establishments located within the boundaries of district:** |

**Please note:** If grant is approved, funding will not be awarded until all signatures are in place. Please obtain all signatures before submitting the application.

**Part IA: Recipient School Information and Signature Page***(Complete and attach after cover page. If necessary, additional copies of this page may be attached in order to include each participating school.)*

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| --- | --- | --- | --- |
| District or BOCES Name: |  |  |  |
| School Name: |  |  | School Code: |
| Principal Name: |  |
| Principal Signature: |  |
| School Address:  |  |
| Phone: |  | Email:  |  |

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| Please answer the following for the Intended Recipient Secondary School(s): |
| Number of School Health Professionals currently employed: |  |
| Current ratio of students to School Health Professionals: |  |
| Current health programs established for students and staff: |  |
| Current Health and Wellness Team including names and roles: |  |
| Current number of students served by School Health Professionals or programs: |  |
| Amount of matching funds able to commit for this grant: |  |
| Number of students (and their grade levels) Secondary School anticipates serving using funds from this grant: |  |
| Number and roles of School Health Professionals Secondary School anticipates hiring using funds from this grant: |  |

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| Part IB: Assurances*(Complete and attach after signature page)* |

**School Health Professional Grant Program**

*The appropriate Authorized Representatives must sign below to indicate their approval of the contents of the application, and the receipt of program funds.*

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|  On | (date) , |  2015, | the Board of | (District, BOCES, or CSI) |

hereby agrees to the following assurances:

1. The grantee will annually provide the Colorado Department of Education the evaluation information required on page 4 and in the Progress Report (Attachment B) of the Request for Proposal.
2. The grantee will work with and provide requested data to CDE for the School Health Professional Grant Program within the time frames specified.
3. In addition to the Education Provider’s proposed plan for training and resources, the grantee will budget for a team to attend grant trainings during the term of the grant.
4. The grantee will not discriminate against anyone regarding race, gender, national origin, color, disability, or age.
5. That funds will be used to supplement and not supplant any moneys currently being used to provide school health professionals or services for students in secondary schools and grant dollars will be administered by the appropriate fiscal agent.
6. That funded projects will maintain appropriate fiscal and program records and that fiscal audits of this program will be conducted by the grantees as a part of their regular audits.
7. That if any findings of misuse of these funds are discovered, project funds will be returned to CDE.
8. The grantee will maintain sole responsibility for the project even though subcontractors may be used to perform certain services.

The Colorado Department of Education may terminate a grant award upon thirty (30) days’ notice if it is deemed by CDE that the applicant is not fulfilling the requirements of the funded program as specified in the approved project application, or if the program is generating less than satisfactory results.

Project modifications and changes in the approved budget must be requested in writing and be approved in writing by the Colorado Department of Education before modifications are made to the expenditures. Please contact both Marti Rodriguez (rodriguez\_m@cde.state.co.us / 303-866-6769) of CDE’s Grants Fiscal Management and Jessica Bigler (bigler\_J@cde.state.co.us) for any modifications.

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| Name of School Board President/BOCES President *(If Applicable)* |  | Signature of School Board President/BOCES President*(If Applicable)* |
|  |  |  |
| Name of District Superintendent*(If Applicable)* |  | Signature of District Superintendent*(If Applicable)* |

|  |  |  |
| --- | --- | --- |
| Name of Charter School Board President*(if applicable)* |  | Signature of Charter School Board President*(if applicable)* |
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| Name of Charter School Institute Authorized Representative *(if applicable)* |  | Signature of Charter School Institute Authorized Representative *(if applicable)* |