EARLY MENTAL HEALTH INITIATIVE
PROGRAM SUMMARY

1. Type of Application proposed for EMHI funding (mark appropriate box with an "X"). NOTE: No more than one of each type of application may be submitted per district, except for districts that are regionalized administratively.

Primary Intervention Program (PIP) ☐ Other Model ☐ Other Model and PIP ☐
Enhanced PIP ☐ Enhanced Other Model ☐ Enhanced Other Model and PIP ☐

2. Expansion of Existing Model to Other Sites Within the LEA: ☐ YES ☐ NO

3. PART 1 HAS BEEN COMPLETED: ☐ YES ☐ NOT APPLICABLE

4. Name of Applicant (LEA) and Mailing Address:	5. County:

Superintendent Name:	Telephone:

6. Project Coordinator Name and Mailing Address:	Summer Address:

Telephone:	FAX:	Summer Telephone:

Project Coordinator E-Mail Address:

7. Name of school sites (in alphabetical order) where proposed model will be implemented. Enter the Cluster or Region Number or Letter after school site, if applicable:	Regional Identifier	A. Augmentation of Existing Services at Listed School Site (X)	B. Modified Traditional (MT) or Year-Round Sites (YR)	C. Receiving Healthy Start Funds (O or P)	D. Formerly EMHI Funded (enter last year of state funding)	E. Locally Funded (enter last year of local funding)
1.		☐				
2.		☐				
3.		☐				
4.		☐				
5.		☐				
6.		☐				
7.		☐				

8. Total Number of Child Aides and **Combined** Number of Hours to be Worked per Week:	9. Estimated Number of Students to Receive Direct Services for One Year with **Grant Funds**:	10. Estimated Number of Parents, Teachers, and/or Students To Receive Indirect Services for One Year with **Grant Funds**	11. Grant Request (One Year):	12. Percent of Grant Request to Total Program Cost:
_____/_____ # of Aides/Combined Hrs.	_____	_____ Parents _____ Teachers _____ Students	$_____	_____%

13. Estimated Cost Per Student (Grant Funds Only) to Receive Direct Services.	14. Total Number of K-3 Students Enrolled at Proposed Sites	15. Cooperating Mental Health Entities:
$_____	_____	

16. Key Professional Staffing Summary:

Name	Role in Program	Hours per Week

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PROGRAM SUMMARY
PAGE 2

17. Clearly describe the basic elements of the proposed services to students, staff, and/or parents:

18. Describe the sequence of implementing the program services from the beginning to end (number each sequence):

19. Name of Person from LEA to Contact:
In the event that there are questions about this application, the following individual will be the only point of contact between the DMH and the LEA.

Typed Name: _____ Title: _____

Email Address: _____

Telephone Number: _____ Date: _____