

**SUTTER COUNTY MEDI-CAL COLLABORATIVE**  
***FUNDING APPLICATION***

2021-2022

**APPLICANT INFORMATION**

Applicant Name:

Date:

Title:

School Site:

Email:

Phone number:

**OVERVIEW OF PROPOSAL**

Describe your request for funding from the Medi-Cal Collaborative.

**PURPOSE OF FUNDING**

Describe how this proposal will meet this un-met need and supplement existing services.

How many students/families do you estimate will directly benefit and for how long?

Describe the administrative support for this proposal.

## TRAINING

**“Complete this section if proposal is to provide and/or host training.”**

Describe the intended audience and size.

Describe the trainer qualifications.

Describe the research basis of the training.

## BUDGET

Object	<u>Amount</u>	<u>Description</u>
(1000-1999: Certificated Salaries)	\$ _____	_____
(2000-2999: Classified Salaries)	\$ _____	_____
(3000-3999: Employee Benefits)*	\$ _____	_____
(4000-4999: Books & Supplies)	\$ _____	_____
(5000-5999: Services, Training)	\$ _____	_____
(6000-6999: Equipment)**	\$ _____	_____
(7000-7999: Indirect (12.09% through June 30, 2022 for SCSOS/Infant Program Only)	\$ _____	_____
TOTAL ESTIMATED BUDGET	\$ _____	_____

\*The cost of statutory benefits must be included (3000-3999: Employee Benefits) when salaries are paid.

## SIGNATURES

*By signing this form, you confirm that you and your administrator have discussed this proposal and understand that you are responsible for implementing the proposal as outlined if this proposal is funded.*

\_\_\_\_\_  
*Applicant's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Site Administrator's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*District Administrator's Signature*

\_\_\_\_\_  
*Date*