



## Promoting Healthy Living & Mental Wellness Program Information

From the following list please select the **(1)** priority that this program addresses.

Adult Mental Health	Seniors	Individuals with Disabilities
<input type="checkbox"/> Clinical services for serious/persistent mentally ill individuals including case mgmt.	<input type="checkbox"/> Home health care	<input type="checkbox"/> Adult day services to include life skills education and/or employment
<input type="checkbox"/> Counseling and/or support groups for those experiencing life difficulties	<input type="checkbox"/> Adult day care	<input type="checkbox"/> Therapeutic and educational day care for special needs children
<input type="checkbox"/> Consumer and/or caregiver information and education	<input type="checkbox"/> Promoting Independence	<input type="checkbox"/> After school programs
		<input type="checkbox"/> Promoting Independence

1. What are the community/participant problems, issues and challenges being addressed by this program. Cite sources to support your statement. (County sources most helpful when available.)

2. How does this program specifically address the impact issue(s) chosen above?

3. Describe the goals of this program: (Consider the problem and what impact you want to have on the problem.)

4. Target Population: Describe, as specifically as possible, the clientele this program is serving.

Number of individuals/clients served in the:

Current budget year: \_\_\_\_\_ proposed budget year: \_\_\_\_\_

5. Specify the geographic area this program will serve:

6. Provide specific information on your degree of success in meeting the program outcomes including numbers and percentages, presented in last year's packet. Please restate outcomes. (if this program was not funded by UWCMC last year, please still indicate the program's success)

7. Describe a unit of service for this program: (i.e. a client, session, phone call)

8. Provide the number of units of service provided in the current budget year \_\_\_\_\_ and the proposed budget year \_\_\_\_\_.

9. Describe how the program will be accessible to the target population. (i.e. location(s), transportation, hours of operation, mobile services, etc.)

Is the program location handicap accessible?     Yes     No

10. Please list and describe any collaborative efforts the agency and program actively participates that directly contribute to the achievement of the outcomes listed.

11. Are there fees charged for this program?  Yes  No  
If yes, what is the agency's policy regarding individuals who cannot pay?

12. Describe volunteer involvement in the program including the number of volunteers and the general functions they perform. If volunteers are not utilized, why not?

13. Does another program in Cape May County provide a similar service? If yes, why is there a need for more than one program? How is your program unique?

14. Within two paragraphs please provide additional information, if any, you feel is pertinent to this program that may not have been addressed by the previous questions.

Please complete the following: Does the agency have a website?  Yes  No  
If yes, does the site include links to: United Way of Cape May County