Strengthening Families
Program Information

Agency Name: ____

Program Title: ____

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

Healthcare	Family Support for At-Risk Families	Domestic Violence
❑ Wellness visits	❑ In-home family counseling, including support groups	❑ 24 hour hotline
❑ Eye Examinations	❑ Outpatient family counseling	❑ Emergency shelter
❑ HIV/AIDS Education	❑ Parenting Classes	❑ Counseling
❑ Prescription Assistance		❑ Legal advocacy and support
❑ Primary Medical Assistance		

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?