

MENTAL WELLNESS AND ADDICTIONS RECOVERY FUNDS

 APPLICATION FORM

2024-2025



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# Identification

|  |
| --- |
| Contact Name: |
| Organization Name: |
| Phone Number: | Email: |
| **Mailing Address** |
| Apartment, Street Number and Name, P.O Box |
| Community | Territory**NT** | Postal Code |

# Funding Information

Please identify which fund you are applying for (Please check all that apply):

|  |  |
| --- | --- |
| [ ]  Community Suicide Prevention Fund | [ ]  Community Wellness and Addictions Recovery Support Fund |
|  |  |
|  |  |

For more information about the specific requirements of each fund please visit:

* [www.hss.gov.nt.ca/funding](http://www.hss.gov.nt.ca/funding)

## APPLICATION INSTRUCTIONS

* If you are applying to multiple funds to support the same project:
	+ Please ensure that your proposal clearly identifies linkages between each of the fund mandates and your project.
	+ Please used the provided budget template.
* If you are applying for a number of different projects:
	+ Please complete a separate application form and budget for each project.

If you have any questions please reach out to us at mha@gov.nt.ca

# Program Information

## Program Title

### Program Description

Describe what you have planned, and what you plan to do. Include location of your program, dates, and target groups (e.g., age and gender).

### Program Evaluation

Describe how your program will make a difference. Include what you want to accomplish.

### Community Partnership

Describe the community partnership and the number and type of supports provided by them to enhance the delivery of the program.

# Budget

Please detail how much you anticipate spending on each budget line item. Please use the [attached excel spreadsheet](https://www.hss.gov.nt.ca/sites/hss/files/resources/application-budget-mental-wellness-addictions-recovery-funds.xlsx) for your proposed budget.

# Declaration

This information is being collected under the authority of the *Access to Information and Protection of Privacy Act* (ATIPP), section 40(c)(i), the *Health Information Act* (‘HIA’), and the associated Regulations. The information will be used for the purposes of monitoring the Mental Wellness and Addictions Recovery Funds and programs and for the general administration and enforcement of these funds and programs.

The privacy provisions of ATIPP and the HIA protect this information, and I understand the information provided in this application may be accessible under ATIPP and HIA. Any questions relating to the collection, use, or disclosure of personal (health) information on this form may be directed to the Mental Wellness and Addictions Recovery Division by emailing mha@gov.nt.ca.

I certify that the information given is accurate and complete, and that the reporting is fairly presented.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of spending authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of signature (day/month /year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send completed applications to: mha@gov.nt.ca or Fax: (867) 873-7706.