|  |  |
| --- | --- |
| Program Title: | |
| Name of Organization: | |
| Contact Name/Title: | |
| Mailing Address: | |
| Phone: | Fax: |
| Email: | |
| Total funding applied for: | |
| 1. Description: (Goals & Objectives, How planned activities link to increasing community wellbeing, while also increasing mental health and suicide awareness? Details on the location, activities, dates, target groups, etc...) | |
| 2. How do the planned activities link to your larger community/regional wellness goals and objectives? | |
| 3. Describe how the planned activities will be delivered with some level of partnership with your Regional Health and Social Services Authority? (Examples could include partnering with your local health centre, Community Counselling Program, or local Child and Youth Care Counsellor) | |
| 4. Program evaluation plan: how are you going to evaluate the activities? (How will you know you have achieved your objectives?)  *DHSS will support communities by making departmental evaluation research and resources available if requested.* | |

WORKPLAN

|  |  |  |  |
| --- | --- | --- | --- |
| Program Activities: What are you going to do? | Program Outcomes: What you do want to accomplish? | Success Indicators: How will you know it worked? | Linkages: who will you work with? Who are the partners?  Have you connected to partners? Have identified partners been contacted and have they committed to participate? |
|  |  |  |  |

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| --- | --- |
| BUDGET  Community Suicide Prevention Fund Project | Anticipated Project Costs |
| 1. Community Suicide Prevention Fund |  |
| Budget description: |  |
| 1. Subtotal |  |
| 1. Administration – (maximum 5% of B): |  |
| Total Anticipated Project Costs (B+C): |  |

|  |  |
| --- | --- |
| Project start date: | Project end date: |

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| --- |
| Declaration of Applicant  This information is being collected under the authority of the *Access to Information and Protection of Privacy Act* (ATIPP), section 40(c)(i) and the Regulations. The information will be used to determine eligibility for funding through the On the Land Healing Fund and for the general administration and enforcement of this fund.  The privacy provisions of ATIPP protect my information, and I understand the information provided in this application may be accessible under ATIPP. Any questions relating to the collection and use of personal information on this form may be directed to Ethel Blake, Consultant, Land Based Healing and Community Development and contact SuicidePrevention@gov.nt.ca.  COVID-19 Considerations  I understand I am responsible for complying with orders made by the Chief Public Health Officer under the NWT’s *Public Health Act*. I understand the Department of Health and Social Services is not responsible for ensuring this project complies with any current or future orders made by the Chief Public Health Officer.  I certify that the information given is accurate and complete. |
| Signature/Title of the spending authority:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of signature (day/month /year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Send completed applications to: [SuicidePrevention@gov.nt.ca](mailto:SuicidePrevention@gov.nt.ca) .