

New Jersey Department of Military and Veterans Affairs
Division of Veterans Healthcare Services

WELFARE FUND PROJECT REQUEST FORM

Calendar Year Ending _____ 20____

Date of Request: _____

Facility: _____

Facility Address: _____

Contact Person: _____

Contact Person's Telephone Number: () _____

Purpose (Include Proposed Resident Utilization Plan): _____

Project Description: _____

Justification (Include Population Benefiting): _____

Expected Start Date (Month/Year): _____

Expected Completion Date (Month/Year): _____

Total Cost: Year #1 _____ Year #2 _____ Year #3 _____ Project Total: _____

Explanation of Required Quotes or Bids: _____

Source of Project Funds: _____

Source of Operational and/or Maintenance Funds: _____

Facility Approval:

Prepared by: _____ Date: _____

Signature: _____ Title: _____

Approved by: _____ Date: _____

Signature: _____ Title: Chief Executive Officer

Approved by: _____ Date: _____

Signature: _____ Title: FAC Chairperson

NJ Department of Military and Veterans Affairs Approval:

Approved: _____ Disapproved: _____ Date _____

Name: _____ Title: The Adjutant General

Signature: _____

Remarks: _____