

APPLICATION OVERVIEW

AGENCY-SPECIFIC INFORMATION

Official Name of Agency: _____

Type of Agency: State County Municipality Nonprofit

Address: _____

City/State: _____ Zip Code +4: _____ - _____ County: _____

UEI Number: _____ Federal ID Number: _____

Website: _____ Fiscal Year Start Date: _____

PROJECT-SPECIFIC INFORMATION

Project Title: _____

Type of Project: New Continuing Expansion

Amount Requested: \$ _____ Federal \$ _____ Match \$ _____ Total

This Project Provides:

- Direct Services Legal Services Training Outreach Services
 Other (Please Describe) _____

Geographic Area to be Served: Indicate the service area of this project by county or municipality name(s). Write statewide if all counties in New Jersey will be served by this project.

Estimated Percentage of Crime Victim(s) to be Served: (Please indicated percentage(s) below, total percentage(s) must equal 100%)

- | | | |
|---|--|--|
| <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Child Abuse/Neglect |
| <input type="checkbox"/> Human Trafficking | <input type="checkbox"/> Dating Violence | <input type="checkbox"/> Elder Abuse |
| <input type="checkbox"/> Homicide Survivors | <input type="checkbox"/> Stalking | |

Project Population Served: Indicate whether this project is serving a special or underserved population of victims? (e.g., Latino/a, African American, Asian-American, Disabled, Elderly, LGBTQ, Immigrant, etc.).

- Yes No

If yes - indicate the population(s): _____

One Paragraph Description of your Project:

Indicate if your agency provides the following services/programs to crime victims:

- | | |
|---|--------------------------------|
| Emergency/crisis response | Long term counseling |
| Criminal Justice advocacy | Short term counseling |
| Legal advocacy | Support groups |
| Courtroom advocacy | Victim outreach |
| Housing advocacy | Community Education |
| Financial advocacy | Hotline |
| Legal services | Emergency financial assistance |
| In-person information/referral | Telephone information/referral |
| Economic development/networking services | |
| Services for the children of victims (e.g., babysitting, recreation, etc.) | |
| Shelter – If checked, indicate the number of beds available: _____ | |
| Transitional Housing – If checked, indicate the number of family housing units: _____ | |

Indicate if your agency has programs for the following types of crime victims:

- | | | |
|--------------------|-------------------|---------------------|
| Sexual Assault | Domestic Violence | Child Abuse/Neglect |
| Human Trafficking | Dating Violence | Elder Abuse |
| Homicide Survivors | Stalking | |

Core Staff

Executive/Agency Director, Name/Title:			
Street Address, City, State, Zip Code +4 (if different from above)			
Telephone:	Ext.	Email:	Fax:
Project Director, Name/Title:			
Street Address, City, State, Zip Code +4 (if different from above)			
Telephone:	Ext.	Email:	Fax:
Main Point of Contact, Name/Title:			
Street Address, City, State, Zip Code +4 (if different from above)			
Telephone:	Ext.	Email:	Fax:
Chief Financial Officer, Name/Title:			
Street Address, City, State, Zip Code +4 (if different from above)			
Telephone:	Ext.	Email:	Fax:
Fiscal Contact, Name/Title:			
Street Address, City, State, Zip Code +4 (if different from above)			
Telephone:	Ext.	Email:	Fax: