Group Respite Grant Program

Application

Applicant Organization Information	
Organization Name:	FEIN#:
Address:	
City: Zip:	County: State: WI
Contact Name:	
Email:	Phone:

Tell us about the event supporting family caregivers		
Caregiver Café	☐	Overnight? ☐ Yes ☐ No
Caregiver Support Group	☐	Overnight? ☐ Yes ☐ No
Caregiver Activity/Recreation	☐	Overnight? ☐ Yes ☐ No
Caregiver Education/Training	☐	Overnight? ☐ Yes ☐ No
Other (please specify below:	☐	Overnight? ☐ Yes ☐ No
Where will the event/activity be held? (location if different from above)		
When will the event/activity be held? (Date(s))		
Will group respite be provided on the same site as the activity/event? ☐ Yes ☐ No		
If no, where will respite be provided: (facility & location)		
Is this a one-time event or an ongoing event/activity? ☐ One-time ☐ Ongoing		
If ongoing, describe the frequency, i.e., first Monday of every month:		

What impact will your activity/event have on family caregivers?

Tell us about who you plan to provide respite to
What is the target population of care recipients? ☐ <18 ☐18-59 ☐60+
Approximately how many care recipients do you anticipate providing respite?
Who will be the professional paid staff member on-site?
How many individuals will you have to assist with providing respite care?
How many staff are to be paid staff? ________ How many will be volunteers? __________
What will be your client to staff/volunteer ratio? __________ (If it is less than 6:1, the application will not be considered.)

What impact will your activity/event have on care recipients?

Detailed Group Respite Grant Budget i.e. We will pay 5 staff @ $10.00/hr. x 4 hrs. = $200
Stipends:
Materials/Supplies:
Printing/Copying:
Advertising:
Transportation:
Other (be specific):
Total group respite grant funds requested: $

Applicant Acknowledgement/Agreement

1. I, as an authorized representative of the applicant, have reviewed the Group Respite Grant Program ("GRGP") Overview Form and understand and agree to the Terms and Conditions of the GRGP.
2. The applicant understands the GRGP funds will not be disbursed without a completed, signed, grant report by each person who received a stipend per this grant.
3. The applicant agrees to provide a grant report, including demographic information on family caregivers served, and care recipients served using the attached form.
4. The applicant attests that it has no knowledge or awareness that any of its employees/volunteers violate RCAW's conflict of interest policy.
5. The applicant acknowledges that completion of this application does not guarantee approval of grant requests.

By signing below, I, as an authorized representative of Applicant, attest the information contained in this grant application is true and accurate and that I am authorized to sign this application on the applicant's behalf.

Applicant Contact Name (Printed)	Applicant Contact Signature	Date

Submit completed application to:
info@respitecarewi.org
or
1835 E. Edgewood Drive, Suite #105-436, Appleton, WI 54913

RCAW
Respite Care Association of Wisconsin