

Form #1 - APPLICATION COVER

FFY2023 PSSF Statement of Need Proposal

See instructions in Section E of Statement of Need
 Scan, save as a pdf and identify as "son#####_Cover"

Agency Identification of non-profit agencies must be consistent with SoS Registration screenshot.

SoN #

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Agency Name:	Program Name:		
Agency Mailing Address:	City:	County:	
	Zip Code:		
Agency Street Address:	City:	County:	
	Zip Code:		
Executive Director:	Telephone:		
	Email:		

Select only one service model.	If FFY2022 program reapplying, report current PSSF Program ID#: <i>(leave blank if uncertain or if requesting a service model change for this program)</i>	
PSSF Family Support Services (FSS)		
1. Prevention/Early Intervention (PEI)	Funding Request	
2. Home Visiting (HVS)	Federal Award (75%)	
3. Healthy Relationship/Co-Parenting (HMI)		
4. Supports/Svcs for Homeless Youth & Families (SHY)	Cash Match Commitment (25%)	
PSSF Family Preservation Services (FPS)	Proposed Total Cost of Services (100%)	
1. Placement Prevention Services (PPS)		
2. Relative Caregiver/Kinship Family (RCS)		
3. Crisis Intervention Services (CIS)		
4. Residential /Post-Placement After-Care (RAC)		
5. Substance Abuse Family Recovery & Support (STR)		
	Service Area	
	Primary – Identify county where majority of services will be provided <i>(list only one county)</i> :	
PSSF Family Reunification Services (TLR)		
1. Supervised Family Visitation (SFV)	Secondary - List additional counties where services will be available:	
2. Child and Family Advocacy (CFA)		
3. Parent Reunification Services (PRS)		
PSSF Adoption Promotion/Permanency Services(APP)	Caseload	
1. Adoption Promotion/Post-Perm. Support (APS)	Proposed Average Caseload per Month:	
2. Transition and Emancipation Support (TES)	Proposed Number of Total Families/Cases per Year:	

SAO/Vendor #:	EIN #:	ORI/OAC #:
Agency Year End (MM/DD):	DUNS #:	E-Verify #:

Applicant's Organizational Status (select one) Public Entity (city, county or state agency or institution) Private Non-Profit Agency/Organization

Signature

The undersigned confirms that the applicant meets the criteria described in the Statement of Need; has provided accurate information regarding the agency, program and services described in the application; and is able to meet contract requirements, if awarded a contract with DFCS.

Signature of AUTHORIZED Officer (as per Resolution or Authorization)	Printed Name of Officer	Title of Officer *	Date
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(Electronic signature not acceptable)
 *For non-profit applicants, name and title must be same as individual identified on GA Secretary of State registration; for public entities, use individual name and title designated on Authorization