##### Application Cover Sheet (FORM A)

1. Local Collaborative Name:

2. **Targeted Community/Neighborhood:**

#### 3. Name of Person(s) Representing the Collaborative:

Mailing Address:

Physical Address:

Telephone: Fax: Email Address:

4. Signature of Person Representing the Collaborative:

Please indicate which Accreditation is being applied for: (check one only)

* Local Community Collaborative
* Local Community Collaborative with Integrated Services

**Application Checklist:**

* Use only white, 8 1/2” x 11” paper, double-spaced, minimum 12-point typeface.
* Provide a header on each page with the collaborative name and page number, including exhibits, charts etc.
* Staple the application
* Provide one original and four copies of the final document.

All applications must include the following clearly marked items in order:

* Form A: Application Cover Sheet
* Form B: Collaborative Plan of Action
* Form C: Local Collaborative Membership Signatures

Body of the Application

* Section 1: Collaborative Description
* Section 2: Community Needs and Priorities
* Section 3: Collaborative Structure

Applications for Community Collaborative with Integrated Services Accreditation **must also include** the following:

Body of the Application

* Section 4: Service Delivery System
* Section 4 Addendum
* Form D: Collaborative Partner Roles

**Community Collaborative Plan of Action (FORM B)**

*Please use primarily bullet points on this form.*

*Complete as many pages as necessary to describe the community’s primary issues.*

|  |  |  |
| --- | --- | --- |
| OVERARCHING GOAL: Child and Family Well-being in our Community | | |
|  | Community Concern [1]: |  |
|  | Estimated time needed to address this Community Concern: |  |
|  | Which collaborative partners will be primarily focused on this Community Concern? |  |
|  | How will you know if you have successfully addressed this Community Concern? |  |
|  | Have you identified any obstacles that might impact your progress on this Community Concern?  a.  b.  c.  d. |  |
|  | What key strategies will the collaborative partners use to address this Community Concern and successfully deal with identified obstacles?  a.  b.  c.  d. |  |
|  | What resources/partners might still need to be recruited to help address this Community Concern?  a.  b.  c.  d. |  |
|  |  |  |

### Collaborative Membership Roster (FORM C)

###### Please have members print their information. You may duplicate this form as necessary. This information can be provided via sign in at a regularly scheduled collaborative meeting.

### 

|  |  |  |
| --- | --- | --- |
| Collaborative Member Name | Affiliation (resident, agency, school, church, business, etc.) | Signature |
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Collaborative Partnership Roles (FORM D)

*This form is required only for those applying for Local Collaborative with Integrated Service Accreditation.*

*Complete as many pages as necessary to fully list partnership roles as they relate to integrated services.*

Collaborative Name:

Target Community/Population:

|  |  |  |
| --- | --- | --- |
| Partner Agency or  Local Government Agency | Support Role the Partner Agency or Local Government Agency will play in the Implementation of Services | Name, Title, Signature of Authorized Agency Representative |
|  |  | Signature of Authorized Representative: |
| Printed Name/Title: |
|  |  | Signature of Authorized Representative: |
| Printed Name/Title: |
|  |  | Signature of Authorized Representative: |
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