NEIGHBORHOOD RECOVERY INITIATIVE

PARTNER APPLICATION

Please complete the following application and submit it to the NRI Lead Agency, _____

ORGANIZATION NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

CONTACT PERSON: _____ TITLE _____

TELEPHONE: _____ FAX NO.: _____

EMAIL: _____ WEB SITE: _____

COMMUNITY

- ☐ Albany Park
- ☐ Auburn Gresham
- ☐ Austin
- ☐ Brighton Park
- ☐ East Garfield Park
- ☐ Englewood
- ☐ Grand Boulevard
- ☐ Greater Grand Crossing
- ☐ Humboldt Park
- ☐ Logan Square
- ☐ North Lawndale
- ☐ Pilsen-Little Village
- ☐ Rogers Park
- ☐ Roseland
- ☐ South Shore
- ☐ West Chicago (Gage Park, Chicago Lawn)
- ☐ West Garfield Park
- ☐ Woodlawn
- ☐ Cicero
- ☐ Maywood
- ☐ Thornton Township
- ☐ Bremen/Bloom Township
- ☐ Rich/Bloom Township

PROGRAM COMPONENT (Check the component(s) for which you are applying to be a Partner:

1. ☐ Mentoring Plus Jobs
   ☐ Safety Net Works
   ☐ Parent Leadership
   ☐ Reentry Program
   ☐ School-Based Counseling

2. Briefly describe how your organization meets the criteria for this program component (answer for **each** component you are interested in).

3. Describe your experience providing similar services to the target population for **each** component you are interested in.

4. Describe your organization's fiscal, management and program capacity to implement **each** program component you are interested in.

5. Indicate the source, amount and purpose of any public funds your organization has received and managed over the past five years (this is not a requirement; we just want to learn your experience with public funds).

6. Describe your organization's experience with conducting collaborative projects with other organizations in the community.

7. Indicate your organization's willingness to: a) implement the program component(s) as prescribed by IVPA (program requirements will be provided for each component); b) participate in all required training and technical assistance; and c) gather required data and submit quarterly program fiscal reports to the Lead Agency and to IVPA, as requested.

8. Is your organization Medicaid certified (not required; optimal for some components)

___ Yes ___No

Please fax the completed application to _____ at _____
(name) (fax number)

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