



A. CONTACT INFORMATION

1. Primary Contact Person	2. Host Organization & Complete Mailing Address **Must be a Non-Profit Incorporated Body
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3. Phone Number of Contact Person	4. Fax Number of Contact Person
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4. Email of Contact Person	5. Complete Mailing Address of Contact Person
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6. List **participants and organizations** involved in planning this event. (Schools/Health/Nursery School, Day Care, Volunteers, etc.)

B. PROJECT DESCRIPTION

Bright Beginnings Formula:
\$300 base rate + \$5 per preschool child
(based on those who attended in the previous year this event was held)

Should this amount exceeds your requirements, and/or if there are funds carried over from previous events, please adjust your request accordingly.

1. Amount of Request (\$)	2. Area to be served by the Wellness/Readiness Event
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3. Date: _____ Time: _____ Location of Event: _____	4. Number of 3 and 4 year olds expected for screening
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5. Please **list stations and activities** according to **pillars** met through this event. Use additional paper if needed.

LEARNING & LITERACY	POSITIVE PARENTING	PHYSICAL HEALTH & NUTRITION	COMMUNITY CAPACITY BUILDING

6. Please indicate whether or not you will include any the following stations at your event and if so, **who you expect to staff these stations.**

SPEECH AND LANGUAGE	YES/NO	
AUDIOLOGY	YES/NO	
OCCUPATIONAL THERAPY	YES/NO	
PHYSIOTHERAPY	YES/NO	

AMOUNT REQUESTED: \$

7. Complete a **budget summary** clearly indicating expected income and expenses. List all staff costs, travel, materials, training, advertising etc. Continue on additional paper if needed.

<u>Revenue</u>		<u>Expenses</u>	
Monetary Donations		Food/Refreshments	
Fundraising		Promotion (ads,posters)	
Other Funding Sources/Grants (please list source)		Supplies/Handouts	
		Equipment	
		Prizes	
Accumulated Surplus		Travel	
		Postage	
Other (please specify)		Other (please specify)	
Total Revenue		Total Expenses	

8. Community Partners

Please list all community partners and in-kind contributions associated with this event. Use additional paper if required.

<u>Community Partner</u>	<u>In-Kind Services/Resource</u>	<u>Estimated or Actual Value</u>

Please Read and Sign:

I have read and understood the “North Eastman Parent-Child Centred Coalition Grant Criteria and Guidelines”.

If this project is selected, I agree to:

- complete and submit the required evaluation forms in relation to the event by specified deadline date;
- attend the Bright Beginnings Regional Forum and present the results of this project.

Signature: _____

Date: _____

Should you have any further questions or require assistance in completing the application process, please do not hesitate to contact our Regional Coordinator.

Please forward completed application to:

Kelly Barrett, Regional Coordinator
Bright Beginnings, North Eastman Parent Child Coalition
Box 1698
Beausejour, MB
ROE OCO

Phone: 204-266-0662
Fax: 204-268-9490

Email: bbcoordinator@hotmail.com
Website: www.brightbeginningsmanitoba.ca

APPLICATIONS MUST BE POSTMARKED NO LATER THAN JANUARY 31ST, 2017.