CLOUD COUNTY CHEMICAL DEPENDENCY COMMITTEE

APPLICATION FOR FUNDING

Name of Organization:

(Must have been in active operation for at least two years in Cloud County)

CONTACT PERSON: Name:

Address:

City:

Phone:

Project Date(s): –

Purpose for which funds are to be used: Check one or more.

- ☐ **Alcoholism and drug abuse prevention and education.**
- ☐ **Alcohol and drug detoxification.**
- ☐ **Intervention in alcohol and drug abuse.**
- ☐ **Treatment of persons who are/or in danger of becoming alcoholics or drug abusers.**

Amount requested $

Briefly describe program for which money is requested:

***How will this project promote the mission of the Chemical Dependency Committee?**

Will this project advertise and acknowledge the support of the Chemical Dependency Committee? Yes ☐ No ☐
If yes, please explain:

Will an organization representative provide statistical data or relevant information for the committee at conclusion of the project? Yes ☐ No ☐

PLEASE RETURN THIS APPLICATION TO ANY MEMBER OF THE CLOUD COUNTY CHEMICAL DEPENDENCY COMMITTEE. THANK YOU.

***MISSION: To provide alcohol and drug intervention, treatment, prevention and education.**