

Suicide Prevention Support for Health Care Clinics Working with Michigan's Health-Disparate Populations

Applicant organization name			
Street address			
City	State	County	ZIP code
Telephone number	Web site		

Title of the project	Amount requested
Major expense items and estimated amounts <i>(A detailed budget will be requested if you are invited to submit a full proposal)</i>	
Project director name	Title
Telephone number	E-mail address

Type of organization check all that apply: <input type="checkbox"/> FQHC or look-alike <input type="checkbox"/> Other safety net clinic <input type="checkbox"/> Tribal health center <input type="checkbox"/> School-based health center fiduciary <input type="checkbox"/> Rural health center <input type="checkbox"/> Other (specify): _____	Which best describes the area you serve? <input type="checkbox"/> Primary urban <input type="checkbox"/> Primary suburban <input type="checkbox"/> Primary rural
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Applicant organization executive director	
Telephone number	E-mail address
Has your organization received grants within the last 2 years from any of the partner organizations? If yes, describe below. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Describe:	