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Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

SUICIDE PREVENTION APPLICATION FORM 2021/2022

Section A

Date

General Information	
Organization Name:	Key Contact Person:
Phone Number:	Fax Number:
Community:	Email Address:
Mailing Address:	Business Number:

Management of the Project

Project Name	Project Lead - Position and Management Function

Organization Type	Focus of Organization	Use of Funds
* Please provide a copy of your registered legal status	* Please check all that apply	* Please check all that apply
□ Non-Profit Organization	□ Strategic Planning	□ Strategic Planning
□ Community Government	□ Research	□ Research
□ Regional Inuit Organization	□ Community Training	□ Community Training
	□ Social Emotional Learning	□ Social Emotional Learning
	□ Wellness Initiatives	□ Wellness Initiatives
	□ Capital Planning	□ Capital Planning
	□ Reducing impulsive behaviour	□ Reducing impulsive behaviour
	□ Support Networks	□ Support Networks
		□ Other (Specify)

Organizational Details (please add additional pages as required)

What is your organization's Vision, Mission, and Values?

Department of Health
Government of Nunavut
Box 1000, Station 1000
Iqaluit, NU X0A 0H0

Quality Of Life Secretariat
Phone: (867) 975-5700
Fax: (867) 975-5705
Email :inuusivutanninaqtuq@gov.nu.ca

Section B Project Information

Project Name or Title:

Brief Description of Project *Please add additional pages as required
1. What is the objective of your project? The objective of this project is to …

2. How do you plan to carry out your objective? (Mention method of delivery, Activities for project)

3. Who will take part in this project? Age of participants?

4. Will there be elder involvement?

5. What do you see is the benefit of running this program? Change behaviors? Goals of this program?

6. What is the start and end date of the project?

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On the left-hand side of the table Please fill in **all** project costs. Then on the right-hand side, fill in **all** the project funds and the source. In short, left side shows what you will pay for the whole project. One right side, you show where you will get the funds from; therefore, your **total project costs** and your **total project funds** should be the same.

Project Costs- proposal information		Funds Receiving for project	
Rentals		Organizational Funds to be used for program	
Travel		Anticipated GN Suicide Prevention Funds	
Material		Other GN Program Funds	
Trainer Fees		Federal Programs	
Interpretation		Inuit Organizations	
Food		Other(Specify)	
Supplies			
Community Meetings			
Administration			
Other (Specify)			
Total		**Total**	

******PLEASE ADD ADDITIONAL PAGES AS REQUIRED

Applicant's Declaration To the Department Health –Quality of Life

1. I confirm the information given in this application is, to the best of my knowledge and ability, complete, true and correct.
2. I certify that financial assistance from Health is a significant factor in the decision to proceed with this project.
3. I will provide all the information required by Health to complete the assessment of this project.
4. I agree to provide financial information and reports as required in the Grants and Contributions Agreement

Applicant's Signature: Print name:		Date:	

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Email :inuusivutanninaqtuq@gov.nu.ca

Preferred Language of Correspondence:

- □ Inuktitut
- □ Innuinaqtun
- □ English
- □ French

All Information provided to support of your application: Yes ____ No _____

*****OFFICE USE ONLY*****

Date Received

REGION: □ Qikiqtaaluk □ Kivalliq □ Kitikmeot

Witness's Signature:

Print name:

Date:

Approved: Yes_____ NO_____ reason for Denial_____

Director _____

Community Wellness Specialist _____

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