**NIRS Project Data Form**

<table>
<thead>
<tr>
<th><strong>1) Program Type:</strong></th>
<th>☐ LEND ☐ UCEDD</th>
<th><strong>7) Funding Start Date (mm/dd/yyyy):</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2) Fiscal Year:</strong></td>
<td></td>
<td><strong>8) Funding End Date (mm/dd/yyyy):</strong></td>
</tr>
<tr>
<td><strong>3) Title of Project:</strong></td>
<td>No Title</td>
<td><strong>9) Total Funding (Pertains to the entire life of the project, omit punctuation):</strong> $</td>
</tr>
</tbody>
</table>
| **4) Project Abbreviation:** | No Code | **10) Funding Type (Check all that apply):**
|                      |                      | ☐ Grant ☐ Contract ☐ Co-Operative Agreement ☐ University Support ☐ Fees/Per Capital ☐ In-Kind Reimbursement Contributions ☐ Other (Please Specify): |
| **5) Project Code:** | No Code | **11) Current FY Funding Amounts & Sources (REPORT CURRENT FISCAL YEAR AMOUNTS ONLY-Select all that apply; omit punctuation)**
|                      |                      | **FEDERAL**
|                      |                      | • Federal Funding Source-Catalog of Federal Domestic Assistance Number: ____________
|                      |                      | • HHS
|                      |                      |   ○ ACF
|                      |                      |     ■ ADD $__________
|                      |                      |     ■ Other ACF (Please Specify) $__________
|                      |                      |   ○ HRSA
|                      |                      |     ■ MCHB $__________
|                      |                      |     ■ Other HRSA (Please Specify) $__________
|                      |                      |   ○ NIH
|                      |                      |     ■ NICHD $__________
|                      |                      |     ■ Other Institute (Please Specify) $__________
|                      |                      |   ○ CMS (formerly HCFA) $__________
|                      |                      |   ○ CDC $__________
|                      |                      |   ○ AHRQ $__________
|                      |                      |   ○ AOA $__________
|                      |                      |   ○ SAMHSA $__________
|                      |                      |   ○ HIS $__________
|                      |                      |   ○ Other HHS(Please Specify) $__________
|                      |                      | • DOE (Education)
|                      |                      |   ○ OSERS
|                      |                      |     ■ OSEP $__________
|                      |                      |     ■ NIDRR $__________
|                      |                      |     ■ RSA $__________
|                      |                      |     ■ Other DOE (Please Specify) $__________

| **6) Contact Information**
| Contact First Name: |
| Middle Name: |
| Last Name: |
| Title: |
| Highest Degree: |
| Work Address 1: |
| Work Address 2: |
| Work City: |
| Work State: |
| Work Zip Code: |
| Home Address 1: |
| Home Address 2: |
| Home City: |
| Home State: |
| Home Zip Code: |
| Email: |
| Website: |
| Phone ________-_________-__________
  ex. 999-999-9999 |
| Fax ________-_________-__________
  ex. 999-999-9999 |
11) Current FY Funding Amounts & Sources CONT...
(REPORT CURRENT FISCAL YEAR AMOUNTS
ONLY-Select all that apply; omit punctuation)

**FEDERAL CONT…**
- DOJ $________
- DOL $________
- SSA $________
- NSF $________
- HUD $________
- Other Federal-Please Specify $________

**STATE AND LOCAL FUNDING SOURCES…**
(REPORT CURRENT FISCAL YEAR AMOUNTS
ONLY-Select all that apply; omit punctuation)
- Dept. of Social Services $________
- Dept. of Education $________
- Dept. of Health (including Title V) $________
- Dept of Mental Health $________
- Dept of Mental Retardation $________
- DD Council $________
- Vocational Rehabilitation $________
- Medicaid/Medicare $________
- Other State & Local (Please Specify) $________

**OTHER FUNDING SOURCE**
(REPORT CURRENT FISCAL YEAR AMOUNTS
ONLY-Select all that apply; omit punctuation)
- Foundation $________
- Service Organization $________
- Fee for Service $________
- Other (Please Specify) $________

**CURRENT FY FUNDING** (Total from all sources)

12) Type of Action (Check all that apply)
- Advocacy
- Capacity Building
- Systemic Change

13) Core Function (Check all that apply)
- Training
- Research & Evaluation
- Information Development/Dissemination
- TA
- Direct Service

14) Areas of Emphasis (Check all that apply)
- Quality Assurance
- Child Care-Related Activities
- Employment –Related Activities
- Transportation-Related Activities
- Education & Early Intervention
- Health-Related Activities
- Housing-Related Activities
- Recreation-Related Activities
- Quality of Life
- Other (Please specify)

15) Target Audience (Check all that apply)
- Students/Trainees
- Professionals/Paraprofessionals
- Family Members/Caregivers and Persons with
  DD/Children with Special Health Care Needs
- General Public
- Not Applicable
- Other-(Please Specify):

16) Unserved or Underserved Populations (Check all that apply)
- Racial or Ethnic Minorities
- Individuals from Disadvantaged Circumstances
- Individuals with Limited English Proficiency
- Individuals from Underserved Geographical Areas
  - Empowerment Zone
  - Reservation
  - Urban
  - Renewal Community
  - Rural/Remote
  - Territory
  - Other (Please Specify):
- Specific Groups within the Population of Individuals
  with Developmental Disabilities (Please Specify):
- Other-(Please Specify):
- Project Does Not Serve an Unserved/Underserved Population
17) **Collaborating Agency(ies)** (Check all that apply and supply the name of the agency in the space provided)

- [ ] State Title V Agency (*Please specify)*:
- [ ] Other Maternal Child Health Bureau Program (*Please specify)*:
- [ ] Developmental Disabilities Council (*Please specify)*:
- [ ] Protection and Advocacy Organization (*Please specify)*:
- [ ] UCEDD (*Please specify)*:
- [ ] Child Care/Early Childhood/Part C Infants and Toddlers (*Please specify)*:
- [ ] Head Start/Early Head Start (*Please specify)*:
- [ ] State Local Special Education (3-21) (*Please specify)*:
- [ ] State Local General Education (*Please specify)*:
- [ ] Post Secondary Education (Community College/University) (*Please specify)*:
- [ ] Aging Organization (*Please specify)*:
- [ ] State/Local Social Services (*Please specify)*:
- [ ] Health Agency Public/Private (*Please specify)*:
- [ ] Mental Health/Substance Abuse Agency (*Please specify)*:
- [ ] Employment/Voc Rehab (*Please specify)*:
- [ ] State/Local MR/DD Agency or Provider (*Please specify)*:
- [ ] Housing Agency/Provider (*Please specify)*:
- [ ] Recreation Agency (*Please specify)*:
- [ ] Consumer/Advocacy Organization (*Please specify)*:
- [ ] State/Local Coalition (*Please specify)*:
- [ ] Legislative Body (*Please specify)*:

- [ ] Justice/Legal Organization (*Please specify)*:
- [ ] Community or Faith-Based Organization (*Please specify)*:
- [ ] Other (*Please specify)*:
- [ ] No Collaborating Agency

18) **Consumer Participation Role** (Check all that apply)

- [ ] Paid Staff
- [ ] Consultant
- [ ] Advisory Committee/Council
- [ ] Task Force
- [ ] None
- [ ] Other (*Please specify)*:

19) **Geographic Scope** (Check all that apply; may specify location in space provided)

- [ ] Single County/Local
- [ ] Multi-County
- [ ] State:
- [ ] Multi-State/Regional
- [ ] National
- [ ] International
- [ ] Other
- [ ] Not Applicable

20) **Key Words** (List three to five key words or phrases)

_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________

21) **Project Description** (Using 500 words, provide an overall project description or abstract that includes: 1) need; 2) overall goals; 3) unusual features; and 4) expected benefits. Continue on back if more space is needed)

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