



CDP Consumer Development Program Application

A Program of Canadian Mental Health Association 103-1873 Main Street, Penticton BC V2A 5H2

For More information contact Bruce @ 778-559-1832

Name: ______ Phone: _____

Address: _____

City/T	own: Posta	Postal Code:				
Do Yo	u Qualify?					
menta more t projec rehabi	ng is provided to consumers for projects/activities that emposit illness to grow stronger, gain new skills and develop their things, get closer to employment, or encourage and maintaints/activities may be individual or group oriented and must be illitative plan as developed with your Mental Health worker cumer must be at the meeting to present their Application or	alents so that the n their mental ve e a component or clinician.	ney are able to do vellness. The of an established			
<u> </u>	Example: Program Coordinator, family member					
Please answer the following questions:		(please circle)				
1. 2.	Is the activity that your requesting funding for part of your rehabilitation?	YES YES	NO NO			
3.	Have you approached and been denied other sources of Funding {Example: Social Services, College Grant ect} If (YES) Please indicate where you applied for funding	YES	NO			
4.	What activity are you requesting funding for? (Example: name of course, Please Indicate if this is a group activity (All participants of the group on a separate page and attach to this request)					
	Who does this benefit and why?					
	Please turn over page and continue your application>>>>	>>>>>>	>>>>>>>			

Only pre-approved will be covered. No funds will be issued for or in progress projects. Applications must be received and reviewed prior to event or project.

All applications must be received 3 days prior to a CDP meeting.

Project or Activity Costs (Example: Materials, books etc If there is more than one item, please have an itemized list or quote for the committee to review.)						
We don't make cheques payable to the applicant all cheques are paid to items for purchase or providing the services. Please ask business for the name cheques are to be payable to (Example)						
Amount						
Plus, Taxes						
Total Amount						
It is the applicant's responsibility to include all taxes. Only the am	ount requested will be paid.					
I give the Consumer Development Committee permission to my Mental He the purpose of verifying information pertaining specifically to my applica understand that as a condition of receiving funding, I am required to subbrief report about the project or activity to the Consumer Development Consumer Development Consumer that I do not fulfill these requirement access funds in the future.	tion for consumer funds. I also mit all original receipts and a Committee within 1 month of					
Applicants Signature	Date					
My Mental Health Worker or Clinician's Name is:						
My Mental Health Worker or Clinician's Name Phone:						