



Town of Orleans

Health & Human Services Department

19 School Road, Orleans, MA 02653

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ORLEANS HUMAN SERVICES ADVISORY COMMITTEE

APPLICATION FOR FUNDING FOR FY 2027

Date: _____

Amount Requested FY27: \$ _____

Name of Agency/Organization: _____

Mailing Address:

Street: _____ Town: _____ ZIP: _____

Contact Person: _____ Title: _____

Contact Email: _____ Contact Phone: _____

Agency Mission Statement:

Goals and Objectives for Next Fiscal Year:

List and describe services provided to Orleans clients:

What are the specific needs of Orleans clients that will be addressed?

Number of People Served in Orleans during the last fiscal year? _____

What is your current agency budget for this fiscal year? \$_____

How do you evaluate the effectiveness of your services provided to Orleans clients?

Describe coordination and collaboration of your services with other agencies/organizations:

Please attach your Certification of 501(c)(3) Status.