

LDTF 1 FORM

**DETAILS OF PROJECT TO BE FUNDED AS PART OF THE LOCAL DRUGS
TASK FORCE SERVICE DEVELOPMENT PLAN**

Local Drugs Task Force: _____

PART A: Details of The Project Promoter

Please complete each of the following sections in BLOCK CAPITALS

1.

| |
|--|
| <p>Name of Project Promoter</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Address:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Contact Name</p> <p>_____</p> <p>_____</p> <p>Telephone Number:</p> <p>Fax Number:</p> <p>E-mail:</p> |
|--|

| |
|---|
| <p>President/Chairperson:</p> <p>Name:</p> <p>_____</p> <p>Address:</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---|

| |
|--|
| <p>Secretary or Treasurer:</p> <p>Name:</p> <p>_____</p> <p>Address:</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|--|

| |
|---|
| <p>Tax Reference No: _____</p> <p>And/or</p> <p>Charitable Status (CHY) No:</p> <p>_____</p> <p>Tax District dealing with Tax Affairs:</p> <p>_____</p> |
|---|

| |
|--|
| <p>Date when the group promoting project was established:</p> <p>_____</p> |
|--|

PART B: Project details

NB: The term ‘Project’ means the activity or person(s) funded under the code below

2. Project Code: _____

3. Project Name: _____

4. Channel of Funding: _____

5. What is the *primary* pillar of the NDS your project comes under? (please tick only 1)

| | | | |
|----------------------|---|----------------|---|
| Education/Prevention | ث | Treatment | ث |
| Supply Reduction | ث | Rehabilitation | ث |
| | | Research | ث |

6. What is the primary NDS Action that your project subscribes to? _____

7. Please choose a category that best describes what your project does (if you have more than one category, please list in order of 1,2,3- 1 being the most applicable category)

- | | |
|---|---|
| Access to treatment and rehabilitation | ١ |
| Treatment and harm reduction for drug users | ٢ |
| Rehabilitation of drug users | ٣ |
| Education and prevention | ٤ |
| Family support | ٥ |
| Supply control | ٦ |
| Education and training of drug workers | ٧ |
| Research | ٨ |
| Other _____ | |

8. From the category/categories that you have numbered above, please tick what ‘methods’ are used by the project to reach the target group/s from the method list below?

| <u>Category</u> | <u>Method (Please tick as appropriate)</u> |
|--|---|
| Access to Treatment and Rehabilitation | Outreach ١ |
| | Assessment and Referral ٢ |
| | Pre-induction programmes ٣ |
| | Drop-in services ٤ |
| | Attending local resident groups/community groups ٥ |
| | Mail shots and other advertising ٦ |
| | Contacting drug users in prison ٧ |
| | |

| | | |
|--|--|--|
| Treatment and Harm Reduction | Methadone dispensing service One to one counselling Group therapy Holistic therapies Needle exchange | 99 99 99 99 99 |
| Rehabilitation | Stabilisation programmes Job seeking skills Vocational training Prison link services | 99 99 99 99 |
| Education and Prevention | Group Education Drugs awareness courses/sessions Parenting skills Information dissemination Information events (open days etc) Personal development of young people Improving school attendance Early school leaver programmes Youth diversion programmes Develop peer drug educators | 99 99 99 99 99 99 99 99 99 99 |
| Family Support | Information and advice One to one counselling Group counselling Discussion groups Residential respite breaks Childcare services Drop in services | 99 99 99 99 99 99 99 |
| Supply Control | Community information Community policing fora | 99 99 |
| Education and Training of Drug Workers | Community addiction training courses | 99 |
| Research | Research Studies | 99 |

9. Please outline the GENERAL objective of the project

Please describe whether the overall purpose is to solve or modify the stated problem

10. Please list three KEY objectives of the project- Please define the tasks or intermediate steps taken to meet each objective.

| | |
|----|--|
| 1. | |
| 2. | |
| 3. | |

11. Please list the main target group/s of the project from the list below (maximum of three in order of 1,2,3- 1 being the most applicable)

- **Adult drug users** ☐
- **Young drug users** ☐
- **Recovering/Stabilised drug users** ☐
- **Prisoners and recovering prisoners** ☐
- **Homeless drug users** ☐
- **Families of drug users** ☐
- **Children/young people (at risk) and their families** ☐
- **Service providers** ☐
- **Community residents** ☐
- **Other** _____ ☐

12. If staff is employed through this funding, please complete the following table:

| Job Title | If applicable, which grade and agency is this linked to? | |
|-----------|--|--------|
| | Grade | Agency |
| | | |
| | | |
| | | |

If this is the Project's first LDTF 1 form, please move to Part C (page 8)

13. Project results for 2005 as per objective

| | |
|----|--|
| 1. | |
| 2. | |
| 3. | |

14. Please state the 'total project employment': (The Full time equivalent person years of employment. Part-time and seasonal employment converted to person years on the basis of a 7-hour day)

Paid staff:

Voluntary staff:

15. Please state the 'number of cases' (i.e. the number of separate individuals to whom services were provided within the year)

If your project is delivered on an individual basis only, please answer:

16. Please list the ‘number of visits or consultations’ (i.e. the number of times the service was used during the year)

18. The number of cases closed (i.e. the number of cases in the year where the education, training, treatment, rehabilitation or family support service offered to the client was successfully delivered and service is no longer availed of. Successful delivery means that the client is no longer regarded as being in need of that particular service)

If your project is delivered on a group basis only, please answer:

17. Please state the ‘number of session-hours’ (i.e. the number of sessions in the year by their duration in hours)

21. Numbers completing courses (i.e. Number of individuals in the year who successfully completed courses in education, training, treatment rehabilitation or family support services and who no longer avail of that particular service. Successful completion means that the person attended at least 65 per cent of the sessions offered).

For Methadone treatment services only, please answer:

24. Please state the number in drug substitution treatment that are not misusing drugs (i.e. the numbers and proportion of those in drug substitution treatment that are not misusing drugs at end September of each year).

25. If barriers prevented the project from progressing its specific objectives, please outline them below as per objective.

26. What specific training or educational courses did your staff participate in during the last 12 months?

27. Project's opening/service hours

| Days | | Hours | |
|-------------|---------|--------------|------------|
| قا | Mon-Fri | قا | 9-5 |
| قا | Mon-Sat | قا | Mornings |
| قا | Sun-Sat | قا | Afternoons |
| | | قا | Evenings |

PART C: Funding

If the project relates to a building of premises, please give details of ownership or Leasing arrangements, and your role in the management structure.

Please give a breakdown of the funding separating current and capital costs, and attach a cash flow statement on the lines of APPENDIX 1 below.

Have you already received any funding from another Government Department, State Agency, Local Authority or any EU funded agency for this project?.

Yes

No

If yes specify the name of agency _____
Specify amount € _____

Have you looked for matching funding for this project?

Yes

No

If so please specify from which agency _____
Amount of funding requested € _____

Please specify the amount of NDST funding now requested:

€ _____

DECLARATION

(To be completed by chairperson, Hon. Secretary or Hon. Treasurer of project Promoter)

On behalf of _____

I, _____

wish to apply for funding towards the project/service named on the LDFT form and I declare that all the information given is true and complete to the best of my knowledge and belief. I acknowledge that I have read the terms and conditions relation to “Funding to Support Projects included in the Service Development Plans of Local Drugs Task Forces” and also “Tax and Accounting requirements” and that I agree to comply fully with all of the terms.

Signed: _____

Address: _____

Position Held: _____

Date: _____ Telephone No. _____

Certified by Local
Drugs Task Force
(Chairperson/
Co-ordinator): _____

Address : _____

Date : _____ Telephone No _____

PLEASE NOTE THAT THE FOLLOWING SHOULD BE ENCLOSED WHERE APPROPRIATE:-

1. A Tax Clearance Certificate unless you have charitable Status.
2. Copy of latest audited Accounts including Balance Sheet.
3. Copy of latest Annual Report.
4. Copy of Architects, contractor’s or other estimates.

Forward completed LDFT 1 form and Declaration to Local Drugs Task Force.