DC Department of Corrections
Programs and Case Management Division
NEW PROGRAM/SERVICE PROPOSAL APPLICATION (NPSPA)

INSTRUCTIONS

Thank you for your interest in volunteering with DC Department of Corrections (DC DOC). This application is for service providers who would like to propose a potential institutional program or service at DC DOC. Please complete the application carefully and in its entirety. Incomplete applications will be denied and will not be processed.

GENERAL INFORMATION

DC DOC Facility:	☐ Correctional Treatment Facility (CTF) ☐ Central Detention Facility (CDF)	Date:	
Name of Program/Service Provider:			
Address of Program/Service Provider:			
Name of funding agency for proposed program/service (BJA, CDC):	☐ Office of Victim Services and Justice Grants ☐ Bureau of Justice Assistance ☐ Other:		
Name of Program/Service:			
Contact Name:			
Contact Phone:		Contact Email:	
Program/Service Facilitation:	☐ Virtual or digital facilitation ☐ Combination of both	☐ In-person facilitation	

PROPOSED PROGRAM/SERVICE DESCRIPTION AND ABSTRACT

Background: Describe the purpose of your newly proposed program/service. Also, explain how the proposed program/service supports the overall mission of the District of Columbia Department of Corrections.

Target Population: Identify the needs or problems to be addressed by the program/service. Include the specific target population and any supporting statistical information that you may have.

Desired Outcomes: State the desired goals and objectives to address the needs/problems stated above. Also include what key benefits will DC DOC derive from participation (quantify this if at all possible).

Budget Impact: What is the total anticipated budget? Please provide your budget and narrative worksheet and list the personnel below who will be coming into the facility.

Implementation Horizon: Please provide details on how long (best and worst case scenario) it will take to implement the proposed program/service (from start to completion).

Training Requirement: Please provide us information regarding the proposed program/service training requirement.

Does the proposed program/service have a training requirement?	○ NO ○ YES (If yes, please describe the type of training and provide the number of staff required to be trained)

List of Personnel: Please name the potential personnel and their position title who will be assigned to the program/service.

Position Title	Personnel Name

Evidence-Based /Best and Promising Practices and Program and Performance Measures	
Is this program based on either research or review of program or service at other institutions?	◯ NO (If no, please justify program design and proposed outcomes) ◯ YES (If yes, please summarize research. Attach additional documentation as appropriate)

Evidence-Based/Best and Promising Practices and Program and Performance Measures (Continued)
What proposed performance measures are being used and why? Also, describe and attach any proposed measurement tools.

Evidence-Based/Best and Promising Practices and Program and Performance Measures (Continued)	
Type of data to be collected:	
Frequency and method of collection:	
Will data be collected, evaluated, reviewed, or submitted to an outside agency or researcher?	◯ NO ◯ YES (If yes, please provide outside agency/consultant's name, credentials and experience)

THIS SECTION IS ONLY DESIGNATED FOR DC DOC EMPLOYEES

AREA OF PROGRAM AND CASE MANAGEMENT DIVISION:

- ☐ Resources to Empower and Develop You (READY) Center
- ☐ Residential Substance Abuse Treatment (RSAT) Program Units
- ☐ Women's Programs and Services
- ☐ Youth Rehabilitation Act (YRA) Studies
- ☐ Religious Services
- ☐ Transition Assistance Program (TAP) Unit
- ☐ Behavioral Health Services
- ☐ Case Management Services

PROPOSED NEW PROGRAM/SERVICE APPROVAL

- ○ YES (Pending successful completion of volunteer services application process)
- ○ NO (Please see reasoning for final decision on the next page)

ADMINISTRATIVE APPROVAL:

Area Designee	*Program Administrator*	*Director, READY Center*	*Deputy Director, Programs and Case Management Division*
Signature	Signature	Signature	Signature
Date:	Date:	Date:	Date:

Email form

COMMENTS

Reset Entire Form

REASON FOR DENIAL