



NATIONAL DEVELOPMENT FUND FOR PERSONS WITH DISABILITIES (NDFPWD)

APPLICATION FORM PO/AP/3
ECONOMIC EMPOWERMENT (GROUP PROJECT/

SECTION A: GROUP/ORGANIZATION/ INSTITUTION DETAILS

1. NAME:
2. POSTAL ADDRESS:.....TELEPHONE..... EMAIL.....
SUB COUNTY..... CONSTITUENCY COUNTY.....
3. REGISTERING BODY/ AUTHORITY.....REGISTRATION NO:.....
4. WHEN THE GROUP WAS FIRST REGISTERED? MONTH..... YEAR.....
5. DISABILITY IDENTIFICATION NUMBER:.....
6. HOW LONG HAS THE GROUP BEEN OPERATING? YEARS MONTHS
(MUST HAVE BEEN OPERATIONAL FOR AT LEAST **Six MONTHS** FOR CONSIDERATION)
7. HOW MANY MEMBERS DOES THE GROUP HAVE NOW? MALE FEMALE
WITH DISABILITY..... WITHOUT DISABILITY
8. TYPES OF DISABILITY (ATTACH LIST OF MEMBERS WITH THEIR NATIONAL DISABILITY IDENTIFICATION NUMBER,
NATIONAL IDENTIFICATION NUMBER, TYPE OF DISABILITY)
9. STATE IF YOU HAVE ANY COMMUNICATIONS PREFERENCES:
 TEXT ONLY SIGN LANGUAGE LARGE PRINT BRAILLE OTHER (SPECIFY)
10. OVERALL PURPOSE/GOAL OF THE GROUP
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.....
.....
11. CONTACT PERSON 1 (COMPULSORY)
NAME: NATIONAL DISABILITY ID/NO: NATIONAL ID/NO:
ROLE IN THE GROUP..... CELL PHONE NO.: EMAIL:

12. CONTACT PERSON 2

NAME: NCPWD REG. NO.: NATIONAL ID.:

ROLE IN THE GROUP..... CELL PHONE NO.: EMAIL:

SECTION B: FINANCIAL INFORMATION

1. DOES THE GROUP HAVE A BANK ACCOUNT? YES NO

IF YES, STATE

A) BANK SIGNATORIES (MUST BE PWDs or Parents of PWDs)

- I.
- II.
- III.

B) CURRENT BANK BALANCE..... WHAT IS THE ANNUAL INCOME OF THE GROUP?

C) ACCOUNT DETAILS

ACCOUNT NAME OF GROUP: ACCOUNT NUMBER:

NAME OF BANK:BRANCH:

2. WHAT ARE THE SOURCES OF INCOME/FUNDING?

MEMBERS CONTRIBUTION SAVINGS LOANS GRANTS DONATIONS OTHER (SPECIFY.....)

3. LIST PREVIOUS PROJECTS AND FUNDING

NAME OF PROJECT	FUNDING SOURCE	AMOUNT AWARDED IN KES	YEAR AND DURATION OF PROJECT	OUTCOMES OF THE PROJECT

4. WHAT ASSETS DOES THE GROUP OWN

.....

5. WHAT LIABILITIES DOES THE GROUP HAVE
.....

SECTION C: PROPOSED PROJECT

1. PROPOSED PROJECT NAME:

2. INDICATE THE AREA(S) WHERE THE PROJECT WILL BE IMPLEMENTED

COUNTY(S).....

SUB- COUNTY (s).....

CONSTITUENCY(S).....

3. WHAT ARE THE SPECIFIC OBJECTIVES OF THIS PROJECT?

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.....
.....
.....

4. LIST THE MAIN ACTIVITIES TO BE CARRIED OUT TO ACHIEVE THE ABOVE OBJECTIVES

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.....
.....

5. INDICATE HOW MANY PERSONS WITH DISABILITIES WILL BENEFIT:

MALE FEMALE

6. DESCRIBE HOW THE PROJECT IMPROVE THE LIVES OF PERSONS WITH DISABILITIES AND COMMUNITY

.....
.....
.....

7. DESCRIBE WHAT RELEVANT CAPACITY AND EXPERIENCE YOUR ORGANISATION HAS FOR CARRYING OUT THIS PROJECT?

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.....

8. DO YOU FORESEE ANY CHALLENGES?

YES NO

IF YES, HOW WILL YOU OVERCOME THEM?

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.....
.....

9. ARE THERE OTHER INSTITUTIONS/ORGANISATIONS ALREADY OFFERING SIMILAR SERVICES IN YOUR AREA?

YES NO

IF YES, EXPLAIN WHY YOUR PROJECT IS NEEDED?

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.....

10. HOW MANY MEMBERS OF THE GROUP ARE IN FORMAL EMPLOYMENT?

SECTION D: PROJECT COSTING

A) PROJECT BUDGET (USE SEPARATE SHEET IF NEEDED):

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.....

B) EXPECTED INCOME IN YEAR 1 (USE SEPARATE SHEET IF NEEDED):

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C) SUSTAINABILITY (HOW WILL THE PROJECT SUSTAIN ITS OPERATIONS BEYOND REQUESTED FUNDING)

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.....

SECTION E: DECLARATION

I HAVE ATTACHED THE FOLLOWING INFORMATION:

- COPY OF REGISTRATION CERTIFICATE
- COPY OF GROUP CONSTITUTION/ BY-LAWS
- COPY OF MINUTES (WHERE THE PROJECT WAS DISCUSSED)
- COPY OF BANK STATEMENT (SIX MONTHS TO THE DATE OF APPLICATION)
- LIST OF MEMBERS (FULL NAMES /NATIONAL DISABILITY ID/NO. /NATIONAL ID/NO.)
- RULES / REGULATIONS GOVERNING RUNNING OF TABLE BANKING PROJECT (WHERE APPLICABLE)

I..... CONFIRM THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AM DULY AUTHORIZED TO MAKE THIS APPLICATION ON BEHALF OF MY GROUP/ORGANIZATION/ INSTITUTION.

NAME & SIGNATURE: ROLE IN THE GROUP..... DATE:

SECTION F: FOR OFFICIAL USE BY SOCIAL SERVICES OFFICER

NAME OF OFFICER: SUB COUNTY.....

I DO/ DO NOT [DELETE AS APPROPRIATE] RECOMMEND THIS APPLICATION TO NDFPWD FOR FUNDING.

REASON FOR RECOMMENDATION/ REJECTION:
.....
.....

I CONFIRM THAT I HAVE CHECKED ALL THE RELEVANT ATTACHMENTS ARE PRESENT AND CORRECT

I CONFIRM THAT THIS GROUP/ ORGANIZATION/INSTITUTION IS REGISTERED AND CURRENTLY ACTIVE IN MY COUNTY AS DESCRIBED IN THE APPLICATION

SIGNATURE & STAMP: DATE:

SECTION G: FOR OFFICIAL USE BY NCPWD COUNTY DISABILITY SERVICES OFFICER

NAME OF OFFICER: COUNTY:

I DO/ DO NOT [DELETE AS APPROPRIATE] RECOMMEND THIS APPLICATION TO NDFPWD FOR FUNDING.

REASON FOR RECOMMENDATION/ REJECTION:

.....

.....

I CONFIRM THAT I HAVE CHECKED ALL THE RELEVANT ATTACHMENTS ARE PRESENT AND CORRECT

I CONFIRM THAT THIS GROUP/ ORGANIZATION/INSTITUTION IS REGISTERED AND CURRENTLY ACTIVE IN MY COUNTY AS DESCRIBED IN THE APPLICATION

SIGNATURE & STAMP: DATE:

SECTION H: FOR OFFICIAL USE BY HEADQUARTERS

NAME OF OFFICER DESIGNATION.....

SIGNED AND STAMP.....DATE RECEIVED:REFERENCE NO:.....