SAN BERNARDINO COUNTY | Behavioral Health

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www.SBCounty.gov

RESET

LETTER OF SUPPORT COVER SHEET

Requesting organization:

Date request received: _____ Requested deadline: _____

Briefly describe the nature of the request (include the funding program and the project the funding will support):

Describe the department or County's existing relationship with the requesting agency:

Does the County currently have a Memorandum of Understanding (MOU), contract, or other formal agreement with the requesting entity? ☐ Yes ☐ No

Is the County currently working with the entity on related services or initiatives?

Would this funding request expand or modify that relationship?

Do the proposed activities align with the County and DBH Goals, Vision, Mission and policies?

☐ Yes ☐ No Describe:

Are there any financial implications or obligations to the County ☐ Yes ☐ No
If yes, describe:

Are there any legal implications or obligations to the County or DBH? ☐ Yes ☐ No
If yes, describe:

What members or stakeholders will this impact?

Which DBH programs would this potentially impact?

Is the proposing organization or its activities politically controversial? ☐ Yes ☐ No
If yes, describe:

Describe any other potential issues, concerns or risks:

Program:		Contact:	Phone:
Prepared by:			Date:
DBH Director:			Date: