Grant Proposed Amount $_____

RFA#10-07-07
Attachment II

APPLICANT INFORMATION FORM
Community Primary Care Challenge Grant
RFA #10-07-07

APPLICATION TYPE: ☐ **TIER 1** **OR** ☐ **TIER 2**

Organization Submitting Application: _____

Applicant Address: _____
& Street Address City Zip Code

Federal EIN #:_____ SAP Vendor #:_____

Proposed Project _____
Site Address: # & Street Address City Zip Code

County of Proposed Project Site _____

City/ Borough/Township of Proposed Project Site_____

Census Tract of proposed Project Site_____

Project Director: _____

Mailing Address: _____
& Street Address City Zip Code

Telephone #_____ Fax #: _____ E-Mail: _____

Organization Submitting Application Type (check applicable):

FEDERALLY-FUNDED
____CHC (330)
____Housing Project (340)
____Homeless Shelter (340)

HEALTH DEPARTMENT
____County
____City

OTHER
____Hospital Based Clinic
____Community-Based Clinic
____University Based Clinic
____Certified Rural Health Clinic (Not for Profit)
____FQHC Look-alike
____Free Clinic
____ Health Improvement Partnership
____School Based Health Center
____Other

As an individual with signatory authority of _____, I certify that the information provided in this application and all of its attachments are true and correct as of the date set forth opposite my signature. I also understand that any intentional or negligent misrepresentation (s) of the information contained in this application may result in forfeiture and/or penalty of any grant awarded based on the information provided.

_____ _____
Signature Date

_____ _____
Print Name Title