Agency Capacity & Scope Fillable Form

# Funding Opportunity Information

**CSFA Title:** Maternal and Child Health Program – Family Case Management

**Catalog of State Financial Assistance (CSFA) No.:** 444-80-1674

# Applicant Information

**Common Name (Doing Business As-DBA):** *Click here to enter text.*

**Employer/Taxpayer Identification Number (EIN, TIN):** *Click here to enter text.*

**Business Address**

**Street:** *Click here to enter text.*

**City:** *Click here to enter text.* **State:** *Click here to enter text.* **County:** *Click here to enter text.* **Zip:** *Click here to enter text.*

# Anticipated Capacity & Scope

**Monthly Caseload Anticipated Capacity:** *Click here to enter text.*

**Anticipated Grant Amount** (Caseload x $38 x 12 months)**:** *Click here to enter text.*

**County / Counties Served:** *Click here to enter text.*

**Zip Codes Served** (only if located in Cook, Kane or Metro St. Louis Areas)**:** *Click here to enter text.*

**Number of Service Sites:** *Click here to enter text.*

**Address(es) for Service Site(s):**

**1)**

**Street:** *Click here to enter text.*

**City:** *Click here to enter text.* **State:** *Click here to enter text.* **County:** *Click here to enter text.* **Zip:** *Click here to enter text.*

**2)**

**Street:** *Click here to enter text.*

**City:** *Click here to enter text.* **State:** *Click here to enter text.* **County:** *Click here to enter text.* **Zip:** *Click here to enter text.*

**3)**

**Street:** *Click here to enter text.*

**City:** *Click here to enter text.* **State:** *Click here to enter text.* **County:** *Click here to enter text.* **Zip:** *Click here to enter text.*

If additional space needed, please attach separate document to application

**Community Partnerships & Referral Capacities:** *Click here to enter text.*

If additional space needed, please attach separate document to application

# Anticipated Program Staffing

**Total Number of Case Management Supervisors and their individual credentials:** *Click here to enter text.*

**Total Number of Case Managers and their individual credentials:** *Click here to enter text.*

**Total FTEs for Case Management:** *Click here to enter text.*

**Expected Caseload / Case Manager:** *Click here to enter text.*

**Total Administrative & Support Staff:** *Click here to enter text.*

# Funding Information

**Identify if intending to claim Medicaid Matching for FY19:** Yes No

**Identify if intending to claim indirect costs for FY19:** Yes No

**If documenting indirect costs, identify what rate intending to use: *(Please choose one)***

Negotiated Indirect Cost Rate of *Click here to enter text.*%

De Minimis 10% rate

# Contact Information

## Agency Administrator

**First Name:** *Click here to enter text.* **Last Name:** *Click here to enter text.* **Suffix:** *Click here to enter text.*

**Title:** *Click here to enter text.*

**Telephone Number:** *Click here to enter text.* **Extension:** *Click here to enter text.* **Fax Number:** *Click here to enter text.*

**E-mail Address:** *Click here to enter text.*

## Fiscal Contact

**First Name:** *Click here to enter text.* **Last Name:** *Click here to enter text.* **Suffix:** *Click here to enter text.*

**Title:** *Click here to enter text.*

**Telephone Number:** *Click here to enter text.* **Extension:** *Click here to enter text.* **Fax Number:** *Click here to enter text.*

**E-mail Address:** *Click here to enter text.*

## FCM Program Coordinator

**First Name:** *Click here to enter text.* **Last Name:** *Click here to enter text.* **Suffix:** *Click here to enter text.*

**Title:** *Click here to enter text.*

**Telephone Number:** *Click here to enter text.* **Extension:** *Click here to enter text.* **Fax Number:** *Click here to enter text.*

**E-mail Address:** *Click here to enter text.*