ILLINOIS DEPARTMENT OF HUMAN SERVICES

 100 S. Grand Ave. East, 2nd Floor

 SPRINGFIELD, ILLINOIS 62762

 Division of Community Health and Prevention

**APPLICANT COVER SHEET**

**ATTACHMENT A**

1. APPLICANT ORGANIZATION:

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEIN/TIN NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Attach IRS Form 575K or Form W-9, when applicable

1. DATE OF SUBMISSION:

\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Month Day Year

3. APPLICANT CERTIFICATION:

To the best of my knowledge, the data and statements in this application are true and correct. The applicant agrees to comply with all State/Federal statutes and Rules/Regulations applicable to the program.

AUTHORIZED OFFICIAL:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typed name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature and Date

4. PROJECT PERIOD:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. TYPE OF ORGANIZATION:

 Governmental Entity

 \*Not-For-Profit Corporation

 Corporation

 Medical/Health Care Provider Corporation

 \*Tax Exempt Organization (IRC 501(a) only)

\* Must provide documentation of current status

6. LEGISLATIVE DISTRICT NUMBERS:

CONGRESSIONAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEGISLATIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(State Senate District)

REPRESENTATIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(State Representative District)

7. FOR DEPARTMENT USE ONLY: