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

2. 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: