STATE OF ILLINOIS

DEPARTMENT OF HUMAN SERVICES

Division of Community Health and Prevention

APPLICATION AND PLAN FOR HUMAN SERVICES PROGRAM COVER PAGE

1. APPLICANT ORGANIZATION

NAME: _____

ADDRESS: _____

CITY: _____ **ZIP:** _____

PHONE: ( ) _____

EMAIL ADDRESS FOR AUTHORIZED PROGRAM REPRESENTATIVE:

_____

FEIN NUMBER *(Please attach Form W-9, when applicable):*

_____

DUNS NUMBER: _____

CAGE NUMBER: _____

2. DATE OF SUBMISSION _____ _____ _____
(Month) (Day) (Year)

3. PROJECT PERIOD:

From _____ _____ _____ **to** _____ _____ _____
(Month) (Day) (Year) (Month) (Day) (Year)

4. TYPE OF ORGANIZATION

_____ Governmental entity

_____ Not-for-profit corporation *(Please attach documentation from the Secretary of State's Office regarding the status of your agency)*

_____ Tax-exempt organization (IRC 501(a) only) *(Please attach documentation of current status)*

LEGISLATIVE DISTRICT (Include Congressional, State Senate District and State Representative District for each Sub-Grant 's service area)

Sub-Grant Type	Service Area	Congressional District	State Senate District	State Representative District

ZIP CODE *(Include zip code + 4 for your proposed service area(s) for each Sub-Grant)*

Sub-Grant Type	Service Area	Zip Code + 4

PROJECTED NUMBER OF PARTICIPANTS: _____

IMPORTANT NOTICE

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined in the Illinois State Finance Act, found at 30 ILCS 105/1 et seq. Failure to provide the information requested on this form may prevent your application from being processed.

9. 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)