**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**DEVELOPMENTAL DISABILITIES ADMINISTRATION FUNDING PROPOSAL**

**A. Vendor Information:**

**Organization:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Contact Person:** _____ **Telephone:** _____

**Mailing Address (if other than shown above):** _____

**Federal Employer I.D.:** _____ **Minority Enterprise** ___**Yes** ___ **No**

**Fiscal Year or Period for which Funds are Requested:** _____

**Type of Service Funded:** ___ **Individual Support** ___ **Family Support** ___ **Individual Family Care**

**Performance Measures Detail Attached** ___ **Yes** ___ **No**

**Area/Jurisdiction To Be Serviced:** _____

**Does the Organization Do Fundraising:** ___**Yes** ___ **No**

**Are any of the State supported costs being used to generate fundraising dollars** ___ **Yes** ___**No**

**Type of Proposal:** ___ **New Fiscal Year** ____**New**

---

**B. Affirmations and Signature of Certifying Official: (Mark Appropriate Box(es))**

___ **If the local health officer has not signed below, a copy of this application was sent to that official simultaneously with this submission**

___ **A program narrative is attached for each service.**

**On behalf of the governing board or other executive authority of the above named organization, I affirm that the information and estimates conveyed in this application are true and accurate to the best of my knowledge.**

**Signature:** _____ **Date:** _____

**Name Printed or Typed:** _____ **Title:** _____

---

**C. Third Party Review:**

| Reviewing Official | Signature | Date | Reviewed | Approved | Disapproved | Attached |
|---|---|---|---|---|---|---|
| Local Health Officer | | | | | | |
| Advisory Council | | | | | | |
| Local Govt. Auth. | | | | | | |
| Regional Director | | | | | | |
| Other (Specify) | | | | | | |

**D. For DHMH Use Only** _____