STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICES CONTRACT 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** 9 **Yes** 9 **No**

Fiscal Year or Period for which Funds are Requested: _____

Type of Service To Be Funded: _____

Performance Measures Detail Attached 9 **Yes** 9 **No**

Area/Jurisdiction To Be Serviced: _____

Does the Organization Do Fundraising: 9 **Yes** 9 **No**

Are any of the State supported costs being used to generate fundraising dollars 9 **Yes** 9 **No**

Type of Proposal: 9 **New** 9 **One-Time Only** 9 **Renewal** 9 **Supplement**

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

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

5 **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 _____