STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
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 ___ Yes _____ No

Fiscal Year or Period for which Funds are Requested: _____

Type of Service To Be Funded: _____

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 One-Time Only Renewal 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 MDH Use Only _____