

# APPLICATION COVER SHEET

## CMSP Behavioral Health Grant Pilot Project

1. Applicant: \_\_\_\_\_  
Applicant's Executive Director: \_\_\_\_\_  
Title: \_\_\_\_\_  
Applicant's Type of Entity (public, non-profit, for-profit, etc.): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

2. Implementation Site(s):  
Provider/ Clinic Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Blue Cross/CMSP Contracting Status:  
 Contracted  Non-contracted, not in process  Non-contracted, in process  
Tax ID Number: \_\_\_\_\_ Medicare Provider Number: \_\_\_\_\_

Provider/ Clinic Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Blue Cross/CMSP Contracting Status:  
 Contracted  Non-contracted, not in process  Non-contracted, in process  
Tax ID Number: \_\_\_\_\_ Medicare Provider Number: \_\_\_\_\_

Provider/ Clinic Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Blue Cross/CMSP Contracting Status:  
 Contracted  Non-contracted, not in process  Non-contracted, in process  
Tax ID Number: \_\_\_\_\_ Medicare Provider Number: \_\_\_\_\_

\* Indicate here  and attach a separate sheet(s) with the requested provider/clinic information if more than 3 implementation sites

## CMSP Behavioral Health Grant Pilot Project

Applicant: \_\_\_\_\_

3. Pilot Project Type (select 1):

- Mental Health Counseling Services
- Substance Abuse Counseling Services
- Both – Mental Health and Substance Abuse Counseling Services

4. Funds Requested (Direct Service and Administrative Costs):

	Direct Service:	Site-Level Administrative Costs:
Year 1 (CY 2008):	\$ _____	\$ _____
Year 2 (CY 2009):	\$ _____	\$ _____
Year 3 (CY 2010):	\$ _____	\$ _____
Sub-total:	\$ _____	\$ _____
<b>Grand Total:</b>	<b>\$ _____</b>	<b>\$ _____</b>

5. Primary Contact Person *Role: Serves as primary contact person during the application process.*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

6. Secondary Contact Person *Role: An alternate contact during the application process.*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## CMSP Behavioral Health Grant Pilot Project

Applicant: \_\_\_\_\_

7. Financial Officer *Role: Fiscal agent for project.*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_ ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

8. By submitting this application, the applicant signifies acceptance of the responsibility to comply with all County Medical Services Program Governing Board's requirements stated in this Request for Proposals (RFP). The applicant understands that should the County Medical Services Program Governing Board ("Governing Board") award the grant to the applicant, the Governing Board is not obligated to fund the pilot project until the applicant submits correct and complete documents as required for the grant award agreement and the Governing Board is otherwise satisfied that the applicant has fully met all the Governing Board's requirements for the grant award. The Governing Board shall have sole discretion on whether or not to award any grant.

I declare that I am an authorized representative of the applicant described herein. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Cover Sheet and the attached response to the RFP is true and correct.

Official Authorized to Sign for Applicant:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name & Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_ ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_