

# Attachment A: Application FormTraumatic Brain Injury Grant Request for Proposal

## Instructions

Please complete all fields in this application. Character limits include spaces. If you experience problems with the application or need the application in a different format, please call 651-201-4258. Please submit your complete application via email toCatherine.diamond@state.mn.us with the subject line **“Providing Services to Minnesotans and Their Families Who Have Sustained a Traumatic Brain Injury (TBI) RFP Application – (Insert applicant organization name)”.** Applications may ***not***be mailed or hand delivered to MDH.

**Remember, you must submit the following for the application to be considered complete:**

1. Application Form-Organization information *(****this form****)*
2. Application Narrative Questions *(****Attachment B****)*
3. Work Plan (***Attachment C***)
4. Budget (***Attachment D)***)
5. Due Diligence Review Form (***Attachment E***)
6. Applicant Conflict of Interest Disclosure Form (***Attachment F***)
7. Letters of Support (***if applicable***)
8. Copy of 501c3 (***if applicable***)

## General Information

### Lead Organization

Lead Organization Name:

Executive Director/Chief Executive Officer:

Address:

Web Address:

Federal Employer ID (EIN): Minnesota Tax ID:

### Fiscal Agent (if different from lead organization; leave blank if no fiscal agent)

Lead Organization Name:

Executive Director/Chief Executive Officer:

Address:

Federal Employer ID (EIN):

Minnesota Tax ID:

### Project Contact

Name: Title:

Phone: Email:

### Project Information

**If you do not answer yes to the following two questions, your application will not be considered.**

1. Does your organization qualify as a community-based organization as defined in

M.S. §171.29 subd.2(c). ([Sec. 171.29 MN Statutes (https://www.revisor.mn.gov/statutes/cite/171.29)](https://www.revisor.mn.gov/statutes/cite/171.29)

1. Is your organization registered with the United States Internal Revenue Service under section 501(c)(3) as a tax exempt organization?

### Certification

*I certify that the information contained in this application is true and accurate to the best of my knowledge, and that I submit this application on behalf of the lead organization.*

Electronic Signature:

Title: Date:

Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164
Catherine.diamond@state.mn.us
[www.health.state.mn.us](http://www.health.state.mn.us/)

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To obtain this information in a different format, call: 651-201-3969.