



2021 Mental Health Safety Net Grant

Step 1 GRANT APPLICATION FORM

1. Applicant Organization (This information will be used in drafting the grant contract. Sub-applicants must complete this form as well.)

Legal Name _____

Doing Business As (if different than above): _____

Address: _____ City: _____ State: _____

ZIP: _____

County: _____

Phone _____

Federal ID Number _____ State Tax ID Number _____

Swift ID Number _____ SWIFT Location Code: _____

Remit Address (if Different than above):

Address: _____ City: _____ State: _____

Zip: _____

County: _____

2. Applicant Organization -CEO/Authorized Organization Representative

Name/Title _____ Name/Title _____

Address _____ City: _____

State: _____ Zip: _____

Phone _____

Email address: _____

3. Fiscal Management Officer of Organization

Name/Title _____ Name/Title _____

Address _____ City: _____

State: _____ Zip: _____

Phone _____

Email address: _____

5. Primary Contact for Project Administration

Name/Title _____

Address _____

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

Phone _____ Email address: _____

7. Total number of mental health uninsured patients (not encounters) under the age of 21 served by the applicant from July 1, 2019 to June 30, 2020: _____

(The number from Question #7 will be used to calculate the grant award. Separate documentation must be included with the application.)

I certify that the information contained herein is true and accurate to the best of my knowledge, that no changes were made in the organization's accounting and record-keeping practices or policies for providing free or reduced-cost care to uninsured patients for the purpose of creating eligibility or increasing the organization's allocation, and that I submit this application on behalf of the applicant organization.

Signature of Authorized Official	Print Name	Title	Date