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| CITY OF NEWARK |
| DEPARTMENT OF HEALTH AND COMMUNITY WELLNESSFY2025 REQUEST for PROPOSALEnding the HIV Epidemic(TYPE OR PRINT ALL DATA) |
| **Name of Applicant** |
|  |
| **Street Address** | **City** | **County** | **State** | **Zip Code** |
|  |  |  |  |  |
| **Name and Title of Fiscal Contact** | **Telephone Number** |
|  |  |
| **Street Address** | **City** | **County** | **State** | **Zip Code** |
|  |  |  |  |  |
| **Name and Title of Principal Contact** | **Telephone Number** |
|  |  |
| **Employer ID No.** | **DUNS No.** |
|  |  |
| **Proposed Grant Title** | **Location of Proposed Project (include county)** |
|  |  |
| **Site Locations** |  | **Number** |  |  |
|  |  |  |  |
| **SAM (formerly CCR) Registration Status:**  | **SAM (formerly CCR) Registration Valid Until (Date):** |
| **Will any member of the Board of Directors/Trustees receive any direct or indirect personal or monetary gain from the funding of this grant?** [ ]  YES [ ]  NO |
| **Does any member of the Board of Directors/Trustees serve on any board, council, commission, committee or Task Force which has regulatory or advising influence on the funding program?**  [ ]  YES [ ]  NO |
|  |  |  |  |  |
|  | **Member** |  | **Board, Council, etc.** |  |
| **Location as to where payments should be sent** |
|  |
| **Type of Agency (check one)** |  |  |  |
| [ ]  PRIVATE NON-PROFIT | [ ]  GOVERNMENT |  |  |  |
| [ ]  PRIVATE FOR PROFIT | [ ]  OTHER (Specify) |  |  |  |
| **Agency-Fiscal Year Ends** | **Agency Accounting System:** |  |  |  |
|  | [ ]  CASH BASIS |  |  |  |
|  | [ ]  ACCRUAL BASIS | [ ]  OTHER (specify) |  |  |
|  | 1) Continuation Grant [ ] 2) Expansion Grant [ ] 3) New Project [ ]  | **a. Budget Period Mo./Day/Yr.** |
| Type of Request |  | **FROM:** |  | **through** |  |
|  |  | **b. Project Period Mo./Day/Yr.** |
|  |  | **FROM:** |  | **through** |  |
|  |  |  |  |  |  |
| **If grant awarded, will funds be used to replace other funds which would be available in absence of award?** |  |  |
| [ ]  YES | [ ]  NO |  |  |  |
| COST OF THE PROJECT |
| **1. Total Funds Needed** | **2. FUNDS REQUESTED FROM CITY** | **3. Funds from Other Sources** |
|  |  |  |
|  | **Name** | **Program** |
|  |  |  |
| CERTIFICATION – The applicant certifies that to the best of his/her knowledge and belief, all data supplied in this application and attachments are true and correct, the document has been duly authorized by the governing body of the applicant and further understands and agree that any grant received as a result of this application shall be subject to the grant conditions, and other policies. |
| **NAME AND TITLE OF APPLICANT** | **SIGNATURE OF APPLICANT** | **DATE** |
|  |  |  |