

APPENDIX A. DBHDD GRANT APPLICATION FORM

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

DBHDD GRANT APPLICATION FORM

Please provide complete contact information for a minimum of three (3) officers within the organization.

Mailing Address MAY NOT be a post office box.

Name of Grant:

APPLICANT ORGANIZATION:

Legal Name:

Address:

City: **State:** **ZIP Code:**

Phone: **Fax:** **E-mail:**

Federal ID Number: **State Tax ID Number:**

DIRECTOR OF APPLICANT ORGANIZATION

Name/Title

Address:

City: **State:** **ZIP Code:**

Phone: **Fax:** **E-mail:**

FISCAL MANAGEMENT OFFICER OF APPLICANT ORGANIZATION

Name/Title

Address:

City: **State:** **ZIP Code:**

Phone: **Fax:** **E-mail:**

OPERATING ORGANIZATION (If Different from Applicant's Organization)

Name/Title:

Address:

City: **State:** **ZIP Code:**

Phone: **Fax:** **E-mail:**

CONTACT PERSON FOR OPERATING ORGANIZATION (If Different from Director of Applicant's Organization)

Name/Title:

Address:

City: **State:** **ZIP Code:**

Phone: **Fax:** **E-mail:**

CONTACT PERSON FOR FURTHER INFORMATION ON APPLICATION (If Different from Contact Person for Operating Organization)

Name/Title:

Address:

City: **State:** **ZIP Code:**

Phone: **Fax:** **E-mail:**

Amount Requested: **Type of Organization:**

**GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL
DISABILITIES**

DBHDD GRANT APPLICATION FORM

Please provide signatures of three (3) officers within the organization certifying the information in the application is true and accurate to the best of their knowledge.

**I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE
AND THAT I HAVE SUBMITTED THIS APPLICATION ON BEHALF OF THE APPLICANT'S ORGANIZATION.**

Signature:	Title:	Date:
1.		
2.		
3.		