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| **DEPARTMENT OF HEALTH SERVICES** | | | | | | | | | | | | | **STATE OF WISCONSIN** | | | | | | | | | | |
| Division of Care and Treatment Services | | | | | | | | | | | | |  | | | | | | | | | | |
| F-21276C (12/2022) | | | | | **DCTS ANNUAL GRANT/CONTRACT APPLICATION: CONDENSED** | | | | | | | | | | | | | | | | |  | |
| **Exhibit 1** | | | | | | | | | | | | | | | | | | | | | | | |
| **Use the TAB key to move through this form.** | | | | | | | | | | | | | | | | | | | | | | | |
| Grant/Contract Title (DHS contract administrator to fill-in) | | | | | | | | | | | | | | Contract Period Date (DHS contract administrator to fill-in) | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | From: | | date. | | | | Through: | | | date. |
| Grantee Name – Applicant Agency (as registered with sam.gov, if applicable) | | | | | | | | | | | | | | Employer Identification Number (FEIN) | | | | | | | | | Universal Entity Identifier (UEI) |
| Click here to enter text. | | | | | | | | | | | | | | Click here to enter text. | | | | | | | | | Click here to enter text. |
| Street Address | | | | | | | | City | | | | | | | | | | | | | State | | Zip Code |
| Click here to enter text. | | | | | | | | Click here to enter text. | | | | | | | | | | | | | State. | | Enter zip. |
| Grantee Administrator Name – Grant Contract Coordinator | | | | | | | | | | Phone Number | | | | Email Address | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | Click here to enter text. | | | | Click here to enter text. | | | | | | | | | |
| Street Address | | | | | | | | City | | | | | | | | | | | | | State | | Zip Code |
| Click here to enter text. | | | | | | | | Click here to enter text. | | | | | | | | | | | | | State. | | Enter zip. |
| Grantee Fiscal Contact Name | | | | | | | | Phone Number | | | | | | | | | Email Address | | | | | | |
| Click here to enter text. | | | | | | | | Click here to enter text. | | | | | | | | | Click here to enter text. | | | | | | |
| Area(s) to be Served | | | | | | | | | | | | Counties and/or Tribes (list all covered by this grant) | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | Click here to enter text. | | | | | | | | | | | |
| Number Served (How many persons will receive services during THIS period, enter N/A if not applicable) | | | | | | | | | | | | | | | | | | | | | | | |
| Persons Served: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | |
| If project will be subcontracted or operated as a consortium, list name, and address of each participating agency (attach additional sheets, if necessary). | | | | | | | | | | | | | | | | | | | | | | | |
| Agency Name | | | | | | Address | | | | | City | | | | | | | | State | | Zip | |
| Click here to enter text. | | | | | | Click here to enter text. | | | | | Click here to enter text. | | | | | | | | State. | | Zip. | |
| Agency Name | | | | | | Address | | | | | City | | | | | | | | State | | Zip | |
| Click here to enter text. | | | | | | Click here to enter text. | | | | | Click here to enter text. | | | | | | | | State. | | Zip. | |
| Total Budget Amount Requested (Must match amount on budget template F-01601) | | | | | | | | | | | | | | | Total Dollar Match (If required) | | | | | | | | |
| $Click here to enter. | | | | | | | | | | | | | | | $Click here to enter text. | | | | | | | | |
| Name/Title – Official Authorized to Commit Applicant Agency to this Contractual Agreement | | | | | | | | | | | | | | | | | | Date | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | | | Click here to enter a date. | | | | | |
| Email Address of Authorized Official | | | | | | | | | | | | | | | | | | Phone Number | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | | | Click here to enter text. | | | | | |
| This application has been approved by the official authorized to commit applicant agency to this contractual agreement. | | | | | | | | | | | | | | | | | | | | | | | |
| **Agency Name:** | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |
| **Contract Title:** | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |
| **Contract Period:** | | | From | date. | | | Through | | date. | | | | | | | | | | | | | | |
| **EXHIBIT 1.1**  **DESCRIPTION OF DELIVERABLES/DEMONSTRATION OF NEED/CONTRACT PURPOSE/SERVICES TO BE PROVIDED**  **Abstract** | | | | | | | | | | | | | | | | | | | | | | | |
| **Program Description** (Contract Administrator- please enter brief, one paragraph description of purpose of grant/contract) | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | Provide an overview of the services to be provided and the outcomes or products that will be achieved. (Please limit response to one paragraph) | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | Provide summary data identifying needs and purpose in your region. Justify how this contract funding will address those needs. (Please limit response to one to two paragraphs) | | | | | | | | | | | | | | | | | | | | | | |
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