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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) |
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| 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) |
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| 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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