# **Application Face Sheet**

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| 1. Legal Name of Agency: 2. Name of individual with Signature Authority: 3. Phone number of individual with Signature Authority: | | | | | | | |
| 1. Mailing Address (include zip code+4): 2. Address to which checks will be mailed: | | | | | | | |
| 1. Street Address: | | | | | | | |
| 1. DPP Program Coordinator:   Name:  Title: | | | | | Telephone Number:  Email Address | | |
| 1. DPP Data Manager   Name:  Title: | | | | | Telephone Number:  Email Address: | | |
| 1. Agency Status (check all that apply): | | | | | | | |
| 🞏 Public |  | 🞏 Private Non-Profit |  | 🞏 Local Health Department | | | 🞏 Other |
| 1. Agency Federal Tax ID Number: | | | | | | 1. Agency DUNS Number: | |
| 1. Agency’s URL (website): | | | | | | | |
| 1. Agency’s Financial Reporting Year: | | | | | | | |
| 1. Agency’s DPRP Number: | | | | | | | |
| 1. Current Diabetes Prevention Program Areas (county(ies) and communities): | | | | | | | |
| 1. Proposed Area(s) To Be Served with Funding (county(ies) and communities): | | | | | | | |
| 1. Amount of Funding Requested: | | | | | | | |
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| The facts affirmed in this application are truthful and I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant. | | | | | | | |
| 1. Signature of Authorized Representative: | | | | | | 1. Date | |