

Collin County Health Care Foundation FY 2027 Service Agreement Application

SECTION 1: APPLICANT AND PROPOSAL INFORMATION

1. APPLICANT INFORMATION			
Name of Organization:			
Legal Name, if different:			
Address:			
City:	State: TX	ZIP Code:	
Phone:	Fax:	Web site:	
Mailing Address, if different:			
City:	State: TX	ZIP Code:	
Name of top paid staff:			
Title:	Phone:	E-mail:	
Contact Person regarding this application:			
Title:	Phone:	E-mail:	
Is your organization an IRS 501(c)(3) non-profit? ☐ YES ☐ NO If NO, date applied to IRS for 501(c)(3) non-profit status.			
Employer or Federal Identification Number (EIN or FIN):			

2. PROPOSAL INFORMATION	
Project Title:	
Brief Description of Request:	
Population proposed being served with funds:	
Geographic area served with funds:	
How many unduplicated clients did your agency assist between 1/1/26 – 12/31/26?	
How many unduplicated clients do you anticipate serving between 1/1/27-12/31/27?	

3. BUDGET	
a. Dollar Amount Requested: \$	b. Total annual agency budget: \$
c. Request is ____ % of annual budget (a/b=c)	

4. AUTHORIZATION: Applicant agrees not to discriminate based on race, color, religion, creed, gender, national origin, age, disabilities, marital or veteran status. (Signatory must have contract signing authority.)	
Name:	Title:
Signature:	Date:

SECTION 2: PROJECT NARRATIVE (Insert Here)

SECTION 3: BUDGET NARRATIVE (Insert Here)

SECTION 4B: FEE-FOR-SERVICE BUDGET
Collin County Public Health Foundation
Proposed Service Period: March 1, 2027- February 29, 2028

Service	Unit(s) Proposed	Cost/Unit	Cost
e.g. Sick Medical Visit, Medical Imaging, prescriptive drugs	# Quantity of services estimated	\$ Price of each unit	= Quantity X Price
		Total Cost	\$

SECTION 5: ATTACHMENTS (Insert Here)