Collin County Health Care Foundation
FY 2020 Service Agreement Application

SECTION 1: APPLICANT AND PROPOSAL INFORMATION

1. APPLICANT INFORMATION			
Name of Organization:			
Legal Name, if different:			
Service Delivery 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 1/1/19 – 12/31/19
How many unduplicated clients do you anticipate serving between 1/1/20-12/31/20?

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 Health Care Foundation
Proposed Service Period: March 1, 2020- February 28, 2021

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

SECTION 5: ATTACHMENTS (Insert Here)