

RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE PRISONERS GRANT COVER SHEET

Program title: _____

Administering agency: _____

Administering agency address: _____

Federal funds requested: \$ _____

Required minimum match: \$ _____

Other match contribution: \$ _____

Total: \$ _____

Source of Match: _____

Program Agency: _____

Address (if different than above): _____

Program Director/Phone number: Mr./Ms. _____/(_____) _____

Email: _____ fax (_____) _____

Program Contact/Phone number: Mr./Ms. _____/(_____) _____

Email: _____ fax (_____) _____

Fiscal Contact/Phone number: Mr./Ms. _____/(_____) _____

Email: _____ fax (_____) _____

Administering Agency Federal Tax Identification Number: _____

Program start date: October 1, 2005

Program end date: September 30, 2006

Authorized official for the applicant agency: _____

Signature of authorized official: _____