**Section 630.APPENDIX E Application and Plan for Public Health**

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| ILLINOIS DEPARTMENT OF PUBLIC HEALTH535 WEST JEFFERSON STREETSPRINGFIELD, ILLINOIS 62761APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT |
| 1. | PROGRAM TITLE:BRIEF SUMMARY: |  |
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|  |
|  |
|  |
|  |
| 2. | APPLICATION ORGANIZATION: |
|  |  |
| NAME: |  |  |
| ADRESS: |  |  |
|  |  |
| TELEPHONE: | (\_\_\_) |  |  |
| FEIN NUMBER: |  |  |
| PROJECT DIRECTOR: |  |  |
|  |  |
| FINANCE OFFICER: |  |  |
|  |  |
|  |  |
| 3. | APPLICANT CERTIFICATION: |  |
|  |  |
| To the best of my knowledge, the data and statements in this application are true and correct. The applicant agrees to comply with all State/Federal statutes and Rules/Regulations applicable to the program |  |
|  |  |
| AUTHORIZED OFFICIAL: |  |  |
|  |  |
|  |  |
| Date | Signature |  |
|  |  |
| 4. | TYPE OF ORGANIZATION: |  |
|  |  |  |
|  | LOCAL HEALTH DEPARTMENT |  |
|  | PRIVATE NON-PROFIT AGENCY |  |
|  | OTHER |  |  |
|  |  |
| 5. | GRANT SUPPORT REQUESTED: |  |
|  |  |
| BEGINNING | ENDING | AMOUNT |  |
|  |  |
| 6. | TYPE OF APPLICATION: |  |
|  |  |
|  | INITIAL |  | CONTINUATION |  | REVISION |  |
|  |  |
| 7. | LEGISLATIVE DISTRICT: |  |
|  |  |
| CONGRESSIONAL |  |  |
| LEGISLATIVE |  |  |
| (State Senate) |  |
| REPRESENTATIVE |  |  |
| (State Representative) |  |
|  |  |
| 8. | DATE OF SUBMISSION: |  |
|  |  |
| Month | Date | Year |  |
|  |  |
| 9. | IMPORTANT NOTICE: |  |
|  |  |
| This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 30 ILCS 105. Failure to provide this information may prevent this form from being processed. This form has been approved by the Forms Management Center. |  |
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| ILLINOIS DEPARTMENT OF PUBLIC HEALTH |
|  |  |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT |
|  |  |
| PROGRAM NARRATIVE OR PROGRESS REPORT |
|  |  |
| INSTRUCTIONS: Please complete a narrative in accordance with the instructions found in "Rules and Regulations" for the specific project for which you are requesting funds. If this is a continuation application, please use this page as a progress report in accordance with instructions in the "Rules and Regulations". Following the narrative, please attach a listing of all sites of service and their addresses for this project. |
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| ILLINOIS DEPARTMENT OF PUBLIC HEALTH |
|  |  |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT |
|  | DATE FROM: | THROUGH: |
|  |  |
| SUMMARY BUDGET FOR THIS PERIOD | SOURCE OF FUNDS |
|  | Budget TotalFor Program | ApplicantAnd Other | AmountAssistance Requested |
|  |
|  |  |
| 1. | PERSONAL SERVICES |
|  |  |
| 2. | CONTRACTUAL SERVICES |
|  |  |
| 3. | SUPPLIES |  |
|  |  |
| 4. | TRAVEL |
|  |  |
| 5. | PATIENT CARE |
|  |  |
| 6. | EQUIPMENT |
|  |  |
| 7. | TOTAL DIRECT COSTS |
|  |  |
| SOURCE OF FUNDS – APPLICANT &  | CODE | MATCHING OR COST | OTHER |
| OTHER CATEGORY ONLY |  | PARTICIPATION |  |
|  |  |  | REQUIREMENTS |  |
|  | $ | $ |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |  |  |  |  |
|  | TOTAL | $ | $ |
|  |  |  |  |  |
| USE ADDITIONAL SHEETS IF NECESSARY |  |
|  |  |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH |
|  |  |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT |
|  | DATE FROM:11219 THROUGH: |  |
| DETAILED BUDGETFOR THIS PERIOD(TOTAL COST) | MONTHLYSALARYRATE | NUMBERMONTHSBUDGET-ED | PER-CENTTIME | BUDGETTOTALFORPROGRAM | CO APPLICANTD AND OTHERE | SOURCE OF FUNDSAMOUNTASSISTANCEREQUESTED |
|  |  |
|  | (1) | (2) | (3) | (4) | (5) | (6) |
| 1. | PERSONAL |  |
| SERVICES |  |
| (PositionTitle & Nameof Incumbent) |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
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|  |  |
|  |  |
|  |  |
| FRINGE BENEFITS |  |
| (Rate ) |  |
| CATEGORY TOTAL |
|  |  |
| USE ADDITIONAL SHEETS IF NECESSARY |  |
|  |  |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH |
|  |  |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT |
|  | DATE FROM: | THROUGH: |
|  |  |
| DETAILED BUDGET  | BUDGET TOTAL | C  | APPLICANT |  | AMOUNT |
| FOR THIS PERIOD: | FOR | O | AND |  | ASSISTANCE |
|  | PROGRAM |  | D | OTHER |  | REQUESTED |
|  |  |  |  |
|  | (3) |  | E | (4) |  | (5) |
|  |  |  |  |
|  |  |
| 2. | CONTRACTUAL SERVICES: |  |
| Itemize |  |
|  |  |
|  |  |
| CATEGORY TOTAL | $ | $ | $ |
|  |  |
| 3. | SUPPLIES |  |
| Itemize |  |
|  |  |
|  |  |
| CATEGORY TOTAL | $ | $ | $ |
|  |  |
| 4. | TRAVEL: Itemize |  |
|  |  |
|  |  |
| Mileage (Rateper mile: ¢)LodgingMeals/Per DiemCommercialTransportationOther: |  |
|  |  |
|  |  |
|  |  |
| CATEGORY TOTAL | $ | $ | $ |
|  |  |
|  |  |
|  |  |
| USE ADDITIONAL SHEETS IF NECESSARY |  |
|  |  |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH |
|  |  |
| APPLICATION AND PLAN FOR PUBLIC HEALTH PROGRAM GRANT |
|  |  |
|  | DATE FROM: | THROUGH: |
|  |  |
| DETAILED BUDGET  | BUDGET TOTAL | C  | APPLICANT |  | AMOUNT |
| FOR THIS PERIOD: | FOR | O | AND |  | ASSISTANCE |
|  | PROGRAM |  | D | OTHER |  | REQUESTED |
|  |  |  |  |
|  | (3) |  | E | (4) |  | (5) |
|  |  |  |  |
|  |  |
| 5. | PATIENT CARE: |  |
| Itemize |  |
|  |  |
|  |  |
| CATEGORY TOTAL | $ | $ | $ |
|  |  |
| 6. | EQUIPMENT |  |
| Itemize |  |
|  |  |
|  |  |
| CATEGORY TOTAL | $ | $ | $ |
|  |  |
| 7. | TOTAL COSTS | $ | $ | $ |
|  |  |
|  |  |
| USE ADDITIONAL SHEETS IF NECESSARY |  |
|  |  |
| ILLINOIS DEPARTMEN OF PUBLIC HEALTH |
|  |  |
| APPLICATION AND PLAN FOR HEALTH SERVICES GRANT |  |
|  | DATE FROM:11219THROUGH: |  |
|  |  |
| BUDGET JUSTIFICATION |  |
|  |  |
| INSTRUCTIONS: | Show justification for specific items or categories listed in the detailed budget for which the need is not self-evident. Justifications should clearly indicate that the times being requested are essential to the achievement of the stated project objectives and the conduct of the proposed procedures. |
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|  |  |
|  |  |
| USE ADDITIONAL SHEET IF NECESSARY |  |

(Source: Added at 14 Ill. Reg. 11219, effective July 1, 1990)