Appendix A

Transmittal Form

Apartment Treatment Housing For Adults with Serious Mental Illness

(Please attach to all copies of the proposal)

Date:_____ County(ies): _____

Agency Name: _____

Mailing Address:

Street: _____

City: _____ State: NY _____ Zip Code: _____

Agency Information:

Federal Tax Exempt Identification Number: _____

New York State Charities Registration Number (if Applicable): _____

Contact Person:

Name: _____ Title: _____

E-mail: _____

Phone: _____ Fax: _____

CEO/Executive Director:

Name: _____ Title: _____

E-mail: _____

Phone: _____ Fax: _____

Proposal Components: The attached proposal contains the following:

Brief Program Proposal (20 pages or less) ◯ Yes ◯ No

Start Up and Operating Budget ◯ Yes ◯ No

Budget Narrative (Appendix B1) ◯ Yes ◯ No

_____

Signature of Person Completing Form

Title:_____ **Date** _____