

**CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) DIVISION**

**FUNDING AGREEMENT PERIOD
FY 2023-2024**

AGENCY INFORMATION FORM

Agencies are required to submit an electronic and signed copy (original signatures only) of this form along with their Annual AFA Package.

Agencies are required to submit updated information when updates occur during the fiscal year. Updated submissions do not require certification signatures.

AGENCY IDENTIFICATION INFORMATION

Any program related information being sent from the CDPH MCAH Division will be directed to all Program Directors.

Please enter the agreement or contract number for each of the applicable programs

MCAH _____ BIH _____ AFLP _____

Update Effective Date (*only required when submitting updates*) _____

Federal Employer ID#: _____

Complete Official Agency Name: _____

Business Office Address: _____

Agency Phone: _____

Agency Fax: _____

Agency Website: _____

**AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION**

Please enter the **agreement or contract** number for each of the applicable programs

MCAH _____ BIH _____ AFLP _____

The undersigned hereby affirms that the statements contained in the Agreement Funding Application (AFA) are true and complete to the best of the applicant’s knowledge.

I certify that these Maternal, Child and Adolescent Health (MCAH) programs will comply with all applicable provisions of Article 1, Chapter 1, Part 2, Division 106 of the Health and Safety code (commencing with section 123225), Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 142), and any applicable rules or regulations promulgated by CDPH pursuant to this article and these Chapters. I further certify that all MCAH related programs will comply with the most current MCAH Policies and Procedures Manual, including but not limited to, Administration, Federal Financial Participation (FFP) Section. I further certify that the MCAH related programs will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Service Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. section 701 et seq.). I further agree that the MCAH related programs may be subject to all sanctions, or other remedies applicable, if the MCAH related programs violate any of the above laws, regulations and policies with which it has certified it will comply.

Official authorized to commit the Agency to an MCAH Agreement

Name (Print)	Title
_____	_____

Original Signature	Date
_____	_____

MCAH/AFLP Director

Name (Print)	Title
_____	_____

Original Signature	Date
_____	_____

AFLP Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							AFLP
2	AFLP DIRECTOR							AFLP
3	AFLP COORDINATOR or SUPERVISOR/COORDINATOR							AFLP
4	AFLP FISCAL CONTACT							AFLP
5	FISCAL OFFICER							AFLP
6	CLERK OF THE BOARD or							AFLP
7	CHAIR BOARD OF SUPERVISORS							AFLP
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY							AFLP