Application Cover Sheet

Please list the Executive Director or Manager overseeing the Program.

Full Name (*First and Last Name*): **Title:**

Mailing Address (*Street, P.O. Box, City, State, Zip Code):*

Telephone Number: **Email Address:**

Please list the Hepatitis B Demo Project Contact.

Full Name (*First and Last Name*): **Title:**

Mailing Address (*Street, P.O. Box, City, State, Zip Code):*

Telephone Number: **Email Address:**

Please list the Invoicing Contact/Remittance Contact.

Full Name (*First and Last Name*): **Title:**

Mailing Address (*Street, P.O. Box, City, State, Zip Code):*

Telephone Number: **Email Address:**

Please list the Agreement Signatory with the authority to enter into a grant agreement with the State of California. (Note: For Local Health Jurisdictions this person may be the Chair of the County Board of Supervisors.)

Full Name (*First and Last Name*): **Title:**

Mailing Address (*Street, P.O. Box, City, State, Zip Code):*

Telephone Number: **DUNS (Data Universal Number System):** **FEIN (Employer Identification Number):**

Budget Period: 7/1/2025—12/31/2027
Total Amount Requested for 2.5 Years: $650,000

The undersigned hereby affirms that the statements contained in the application package are true and complete to the best of the applicant's knowledge and accepts as a condition of a Grant Agreement, the obligation to comply with the applicable state and federal requirements, policies, standards and regulations. The undersigned recognizes that this is a public document and open to public inspection. The signature must be in blue ink.

Signature: **Date:**