**MATERNAL, CHILD & ADOLESCENT HEALTH DIVISION**

**Agency Information form (AIF)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Annual** | | **FY:** | | **Program:** | | **Contract #** |
| **Change** | | **Check information changes below:** | | **Effective Date:** | | |
| **Official Agency Name and Address** | | | | | | |
| Agency Name: | | | | | | |
|  | Address: | | | | | |
|  | City: | | | | | Zip: |
|  | Phone: | | Extension: | | | Fax: |
|  | Counties Served: | | | | | |
| **Executive Director:** (*authorized to sign grant agreements)*  **Authorized to sign Budget & Invoices** | | | | | | |
|  | Name: | | | |  | |
|  | E-mail: | | | | Authorizing Signature: | |
|  | Address: | | | | | |
|  | City: | | | | | Zip: |
|  | Phone: | | Extension: | | Cell (Optional): | Fax: |
| **Project Director:  Authorized to sign Budget & Invoices** | | | | | | |
|  | Name: | | | | Project Contact Person |  |
|  | E-mail: | | | | Authorizing Signature: | |
|  | Address: | | | | | |
|  | City: | | | | | Zip: |
|  | Phone: | | Extension: | | Cell (Optional): | Fax: |
| **Project Coordinator:  Authorized to sign Budget & Invoices** | | | | | | |
|  | Name: | | | | Project Contact Person |  |
|  | E-mail: | | | | Authorizing Signature: | |
|  | Address: | | | | | |
|  | City: | | | | | Zip: |
|  | Phone: | | Extension: | | Cell (Optional): | Fax: |
| **Fiscal Officer:  Authorized to sign Budget & Invoices** | | | | | | |
|  | Name: | | | |  | |
|  | E-mail: | | | | Authorizing Signature: | |
|  | Address: | | | | | |
|  | City: | | | | | Zip: |
|  | Phone: | | Extension: | | Cell (Optional): | Fax: |
| **Fiscal Contact:  Authorized to sign Budget & Invoices** | | | | | | |
|  | Name: | | | |  | |
|  | E-mail: | | | | Authorizing Signature: | |
|  | Address: | | | | | |
|  | City: | | | | | Zip: |
|  | Phone: | | Extension: | | Cell (Optional): | Fax: |
| |  |  |  | | --- | --- | --- | | **Names To Be Removed** | | | | Name: | Title: | E-mail: | | Name: | Title: | E-mail: |   **Annual Update:**  Annual update must be e-mailed to the Program Consultant and Contract Manager at the beginning of each fiscal year. Signature of persons authorized to sign budget and invoices and Invoice Cover Letter is only required on faxed copy.  **Change:** Agency information changes must be noted on this form and immediately faxed or e-mailed to the Program Consultant and Contract Manager. Check box (es) to indicate agency information changes, since last submission.  **Project Contact Person:** Please identify only **one** Project Contact Person per agency, responsible for on-going communication with the Program Consultant and Contract Manager.  **Additional Staff Form (ASF):**  For additional staff not listed on AIF. | | | | | | |

Rev 4/14

**MATERNAL, CHILD & ADOLESCENT HEALTH DIVISION**

**ADDITIONAL STAFF ForM (ASF)**

**This form to be used only for additional staff on the grantee’s budget (not listed on the Agency Information Form (AIF).**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Annual** | | **FY:** | | **Program: PREP** | | **Contract #** | |
| **Change** | | **Check information changes below:** | | **Effective Date:** | | | |
| **Official Agency Name** | | | | | | | |
| Agency Name: | | | | | | | |
| **Staff Name and Address** | | | | | | | |
|  | Name: | | | | | |  |
|  | Title: | | | | E-mail: | | |
|  | Address: | | | | | | |
|  | City: | | | | Zip: | | |
|  | Phone: | | Extension: | | Fax: | | |
| **Staff** | | | | | | | |
|  | Name: | | | |  | |  |
|  | Title: | | | | E-mail: | | |
|  | Address: | | | | | | |
|  | City: | | | | Zip: | | |
|  | Phone: | | Extension: | | Fax: | | |
| **Staff Name and Address** | | | | | | | |
|  | Name: | | | |  | |  |
|  | Title: | | | | E-mail: | | |
|  | Address: | | | | | | |
|  | City: | | | | Zip: | | |
|  | Phone: | | Extension: | | Fax: | | |
| **Staff Name and Address** | | | | | | | |
|  | Name: | | | | | |  |
|  | Title: | | | | E-mail: | | |
|  | Address: | | | | | | |
|  | City: | | | | Zip: | | |
|  | Phone: | | Extension: | | Fax: | | |
| **Staff Name and Address** | | | | | | | |
|  | Name: | | | | | |  |
|  | Title: | | | | E-mail: | | |
|  | Address: | | | | | | |
|  | City: | | | | Zip: | | |
|  | Phone: | | Extension: | | Fax: | | |
| **CDPH:** Please check box for each staff member who would like to be on the CDPH ASF.  **Annual Update:** Annual update must be faxed and e-mailed to the Program Consultant and Contract Manager at the beginning of each fiscal year. This form is only required if the grantee has additional staff on the budget (not listed on the AIF).  **Change:** Staffing information changes must be noted on this form and immediately faxed and e-mailed to the Program Consultant and Contract Manager. Check box (es) in first column to indicate changes, since last submission.  **Names to be Removed from CDPH ASF**: Please include names of staff no longer working on this grant. | | | | | | | |

Rev. 4/14