|  |  |
| --- | --- |
| **Title of Application** |  |
| **Legal Name of Applicant** |  |
| **Applicant Mailing Address** |  |
| **City, State, Zip:** |  |
| **Telephone Number (Including Area Code)** |  |
| **Fax** |  |
| **Email Address:** |  |
| **Applicant FEID:** |  |
| **Total Amount of Funding Requested:** |  |
| **Contract Person for Negotiations:** |  |
| **Name of Authorized Official:** |  |
| **Title of Authorized Official:** |  |
| **Signature of Authorized Official:** |  |
| By signing above, you are attesting that:TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED. |
| **Type of Applicant:** | * Community Based Organization (CBO)
* County Health Department
* For Profit
* Front Porch Community
* Individual
* Faith Based
* Other (specify)
 |
| **County(s) Served:** |  |
| **Priority Area(s) Covered:** | * Adult and Child Immunizations
* Alzheimer’s Disease and Related Dementias (ADRD)
* Cancer
* Cardiovascular Disease
* Diabetes
* HIV/AIDS
* Lupus
* Maternal and Infant Mortality
* Oral Healthcare
* Sickle Cell Disease
* Social Determinant of Health (SDOH)
 |

**COVER PAGE**

**FLORIDA DEPARTMENT OF HEALTH**

**OFFICE OF MINORITY HEALTH AND HEALTH EQUITY**

**REDUCING RACIAL & ETHNIC HEALTH DISPARITIES:**

**CLOSING THE GAP**

**RFA # 23-004**