Florida Department of Health
Bureau of Communicable Diseases
HIV Patient Care and Treatment Access Program

FY 2026-2031

FLORIDA STATE HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) PROGRAM
REQUEST FOR APPLICATIONS (RFA)
RFA25-004

APPLICATION FORM

Applicant Business Name: _____

Area(s)/County(ies) to be Served: _____

Annual Amount Requested: _____

Name of Contact Person: _____

Applicant Physical Address: _____

City, State, Zip Code: _____

Phone Number: _____ Email Address: _____

Federal Employer Identification Number (FEID): _____

BY AFFIXING MY SIGNATURE ON THIS APPLICATION, I HEREBY STATE THAT I HAVE READ THE ENTIRE RFA TERMS, CONDITIONS, PROVISIONS, AND SPECIFICATIONS, AND ALL ITS ATTACHMENTS. I hereby certify that my company, its employees, and its principals agree to abide by all of the terms, conditions, provisions, and specifications during the RFA process and any resulting contract including those contained in the Standard Contract.

Authorized Signature: _____

Authorized Signature Printed Name and Title: _____

The application must be signed by an individual authorized to act for the applicant agency or organization, and to assume for the organization the obligations imposed by the terms and conditions of the grant.

This is not a competitive solicitation subject to the notice or challenge provisions of section 120.57(3), Florida Statutes.