

\_\_\_\_\_  
Date Received

**STATE OF NEW JERSEY**  
**DEPARTMENT OF HUMAN SERVICES**  
*Division of Disability Services*  
Cover Sheet

Name of RFP \_\_\_\_\_

Incorporated Name of Applicant: \_\_\_\_\_  
Type: Public \_\_\_\_\_ Profit \_\_\_\_\_ Non-Profit \_\_\_\_\_ Hospital-Based \_\_\_\_\_

Federal ID Number: \_\_\_\_\_ Charities Reg. Number (if applicable)  
\_\_\_\_\_

Address of Applicant: \_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone No.:  
\_\_\_\_\_

Total dollar amount requested: \_\_\_\_\_ Fiscal Year End:  
\_\_\_\_\_

Funding Period: From \_\_\_\_\_ to \_\_\_\_\_

Total number of unduplicated clients to be served: \_\_\_\_\_

County in which housing and services are to be provided: \_\_\_\_\_

Brief description of services by program name and level of service to be provided\*:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorization: Chief Executive Officer (printed name):  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*NOTE: If funding request is more than one service, complete a separate description for each service. Identify the number of units to be provided for each service as well as the unit description (hours, days, etc.) If the contract will be based on a rate, please describe how the rate was established.