SFY 2019 OhioMHAS _____

Grant Application

FACE SHEET

FACE SHEET TYPE (check one)	SERVICE TYPE (check one)
[ ] Original [ ] Revision [ ] Report	[ ] Treatment and Recovery [ ] Prevention [ ] Other

Total OhioMHAS Funds Requested: $ _____

Grant Period: _____ to _____

Implementing Provider Information	
Implementing Provider Name	
Executive Director	
Mailing Address	
City, State, Zip Code	
Telephone Number	
Fax Number	
Executive Director	
Executive Director's Email	
Fiscal Officer's Name	
Fiscal Officer's Email	
Federal Tax ID Number	
ADAMHS/ADAS Board (if applicable)	

_____ _____

Executive Director Signature Date