**2019 – 2020 AmeriCorps State Formula Application Coversheet**

**Catalog of Federal Domestic Assistance Number: 94.006**

**CFDA Title: AmeriCorps State and National Grants - FY 2019**

**Federal Agency: Corporation for National and Community Service**

**\*\*\*\*Program is not covered by E.O. 12372\*\*\*\***

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| **1. APPLICATION IDENTIFIERS** |
| a) Application ID: *(internal use)* | b) Employee Identification Number: | c) Organizational DUNS |
| **2. APPLICANT CONTACT INFORMATION** |
| a) Application Status: | b) Legal Name: |
| c) Type of Applicant: |
| **d) Address:** |
| Street Address/P.O. Box 1: Street Address/P.O. Box 2: City:  County:  State:  Zip Code:  |
| **e) Legislative Information:** |
| State Senator Name: State Representative Name: Congressional District #:  |
| **f) Name and Contact Information of Person to be Contacted on Matters Involving this Application:** |
| Prefix: | First Name: | Last Name: |
| Professional Title: | Organizational Affiliation: |
| Telephone: | Extension: | Fax: | E-mail Address: |
| **g) Name and Contact Information of Person Who Will Administer the Proposed Project (i.e., Program Director):** |
| Prefix: | First Name: | Last Name: |
| Professional Title: | Organizational Affiliation: |
| Telephone: | Extension: | Fax: | E-mail Address: |
| **3. PROJECT INFORMATION** |
| a) Project Title: |
| b) Proposed Project Period:Start Date  End Date  | d) Number of MSYs Requested for the Proposed Project:* Full-time
* Half-time
* Reduced half-time
* Quarter-time
* Minimum-time

**TOTAL # OF MSYs** =  |
| c) Brief Description of Proposed Project: |
| e) Is the Applicant Delinquent on Any Federal Debt? (If “yes”, provide an explanation in the box below.) |
| f) Estimated Funding:* Federal
* Applicant
* State
* Local
* Other
* Program Income
* **TOTAL FUNDING**
 |
| g) Areas Affected by the Project: if services will be provided at more than one site, include an attachment of those sites to include the information below. If the focus area(s) is targeting the entire state, check the ‘Statewide’ box only (by double-clicking on the box and selecting “Checked”).City  Representative County  Congressional District # State  Statewide [ ] Senator  |
| **4. AUTHORIZATION** |
| a) By signing this application, I certify (1) to the statements contained in the list of certifications\*\* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances\*\* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)[ ]  \*\* I AGREE\*\* The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions. |
| **b) Authorized Representative:** |
| Prefix: | First Name: | Last Name: |
| Professional Title: | Organizational Affiliation: |
| Telephone: | Extension: | Fax: | E-mail Address: |
| Signature of Authorized Representative: | Date Signed: |