## **3.2 Application Form**

***Note:*** *A completed Application Form is mandatory. If the Application Form is not completed in full the application may be rejected or for minor deficiencies may receive a 5-point reduction in the scoring total.*

***Instructions:*** *Complete each item. Add extra rows if more space is needed to provide complete response.*

1. **Organization Type**  For-Profit  501(c)(3) Nonprofit
2. **Geographic Area of Service** *(list all locations where in-person services will be provided)*

| Address(es) |  |
| --- | --- |

**C. Applicant Organization**

| Name |  | |
| --- | --- | --- |
| Mailing Address |  | |
| Physical Address |  | |
| City & State |  | Zip (9-digit) |
| Federal Tax ID # |  | |
| DUNS # |  | |

**D. Program Point of Contact**

|  |  |  |
| --- | --- | --- |
| Name |  | |
| Title |  | |
| Phone |  | |
| Email |  | |
| Same mailing address as section B?  Yes  No, use below address information | | |
| Address |  | |
| City |  | Zip (9-digit) |

**E. Fiscal Officer**

| Name & Title |  |
| --- | --- |
| Phone & Email |  |

**F. Subcontracting of Services**

| Does your organization subcontract its services?  Yes  No | | |
| --- | --- | --- |
| Subcontractor |  | |
| Mailing Address |  | |
| Physical Address |  | |
| City |  | Zip (9-digit) |
| Federal Tax ID # | (xx-xxxxxxx) | |

**G. Key Personnel**

| **Name** | **Title** | **Licensed/Certified?**  *If yes, include copy of licenses/certifications in application* |
| --- | --- | --- |
|  |  | Yes, CGAC or CGAC-I  Yes, other  No |
|  |  | Yes, CGAC or CGAC-I  Yes, other  No |
|  |  | Yes, CGAC or CGAC-I  Yes, other  No |
|  |  | Yes, CGAC or CGAC-I  Yes, other  No |

**H. Medicaid Payers of Services**

| Does your organization or its subcontractors bill Medicaid for services?  Yes  No | |
| --- | --- |
| If Gambling Disorder becomes a Nevada Medicaid covered primary diagnosis, list the names of Nevada Medicaid Enrolled Providers employed or contracted by your organization that would be eligible to bill Medicaid for gambling treatment services. |  |

**I. Third-Party Payers of Services**

| Does your organization or its subcontractors bill any third-party payers (e.g. insurance companies) for services?  Yes, specified below  No | | | |
| --- | --- | --- | --- |
| **Third-Party Payers** | **Period** | **Billables Received ($)** | **Percentage of Operating Income (%)** |
|  |  |  |  |
|  |  |  |  |

**J. Current Funding**

|  |  |  |  |
| --- | --- | --- | --- |
| **Funding** | **Type** | **Project Period End Date** | **Amount Awarded ($)** |
|  |  |  |  |
|  |  |  |  |

**K. Certification by Authorized Official**

|  |  |
| --- | --- |
| As the authorized official for the applying agency, I certify that the proposed project and activities described in this application meets all requirements detailed within Appendix A of the Strategic Plan and of the legislation governing the grant as indicated by DHHS and the certifications in the Application Instructions; that all the information contained in the application is correct; that the appropriate coordination with affected agencies and organizations, including subcontractors, took place; that this agency agrees to comply with all provisions of the applicable grant program and all other applicable federal and state laws, current or future rules, and regulations. I understand and agree that any award received as a result of this application is subject to the conditions set forth in the Notice of Subaward and accompanying documents. | |
| Name (type/print) | Phone |
| Title    Signature | Email    Date |