**ATTACHMENT A**

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**DIVISION OF WHOLE PERSON CARE**

# Vendor Pool for Family Case Management Services

# RFP-HHS-2022-08

***Date:*** _____

| **Legal Applicant:** |
|---|
| Organization Name: |
| Address: |
| Telephone: |
| E-mail: |
| Contact Person: |
| Contact Person's E-mail Address: |
| Type of Organization (if Applicable): |
| Date of Submission: |
| **Federal Tax ID No.:** |

**Certifications**

I certify that to the best of my knowledge the information contained in this Application is accurate and complete and that I have the legal authority to commit this agency to a contractual agreement. I understand that final funding for any service is based upon funding levels and the approval of the Marin County Board of Supervisors.

I further certify that the costs of the proposed project can be carried by the applicant for at least 60 days at any point during the term of the contract.

Signature: Date:

Name:

Title:

***For County Use Only***

| **Date Received:** | **Time Received:** |
|---|---|
| **Marin County WPC Staff Signature Acknowledging Receipt of Application:** | |