ATTACHMENT A

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

Services to Support the 2024 and 2026 Unsheltered Point In Time Counts

RFP-HHS-2023-18

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 Whole Person Care Staff Signature Acknowledging Receipt of Application:	

ATTACHMENT D

Whole Person Care Division PROGRAM NAME Budget		
Proposed Program Budget: FY 2024-2026		
	Budget:	**Budget Explanation:**
PERSONNEL EXPENSES: (Title; $/hour; and hr/week)		Description of direct services provided to program:
Employee Benefits		@ X% of salary
Total Personnel Expenses:	**$0.00**	
DIRECT PROGRAM EXPENSES:		
Direct Program Expenses:	**$0.00**	
SUBCONTRACTORS:		
Total Subcontractor Expenses:	**$0.00**	
INDIRECT:		
		@ X% of budget
Total Indirect Expenses:	**$0.00**	
TOTAL PROPOSED BUDGET FOR ON-GOING COSTS:	**$0.00**	
ONE-TIME COSTS:		
Total One-Time Expenses:	**$0.00**	
TOTAL PROPOSED BUDGET:	**$0.00**	