## Appendix B: Title Page

**Expansion and Enhancement of**

**Medication-Assisted Treatment for Opioid Use Disorder in Chicago**

**TITLE PAGE**

|  |
| --- |
| Applicant Agency Name: |
| Agency Administrative Mailing Address (*street address, city, state, and zip code*): |
| Agency Service Site Address *(If proposal includes more than one service site, please use additional spaces provided on the following page)*:  |
| Agency Tax Identification Number: | Total Amount Requested: | Medication Type (*check all the apply*)[ ] Methadone [ ]  Buprenorphine [ ]  Naltrexone |
| Executive Director/CEO Name: |
| Executive Director's Phone Number: | Executive Director's Email Address: |
| Primary Program Contact Person: |
| Primary Program Contact's Phone Number: | Primary Program Contact's Email Address: |
| Fiscal Agent Name of Organization and Key Contact Person (if applicable): |
| Fiscal Organization Mailing Address: |
| Fiscal Agent's Phone Number: | Fiscal Agent's Email Address: |
| Signature of the Executive Director/CEO: Date: |

**ADDITIONAL SERVICE SITES**

|  |
| --- |
| Agency Service Site Address: (*street address, city, state, and zip code*): |
| Agency Service Site Address: (*street address, city, state, and zip code*): |
| Agency Service Site Address: (*street address, city, state, and zip code*): |
| Agency Service Site Address: (*street address, city, state, and zip code*): |
| Agency Service Site Address: (*street address, city, state, and zip code*): |
| Agency Service Site Address: |