## 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: |