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|  | **Proof Alliance***Preventing fetal alcohol spectrum disorders and supporting all impacted* |

**Family-Centered Long-Term Recovery Supports Grant Application Form**

**Reference Face Sheet**

**Legal Lead Name of Organization:**

Address:

County:

Telephone: Website:

Federal Tax ID Number: State Tax ID Number:

**Name of Project Director:**

Title:

Telephone: E-mail:

**Name of Financial Officer:**

Title:

Telephone: E-mail:

*Include tax information if different from Lead Organization:*

*Federal Tax ID Number: State Tax ID Number:*

**Name of person authorized to sign contracts:**

Title:

Telephone: E-mail:

Checks would be made payable to:

Address checks would be mailed to:

Dollar amount requested from Proof Alliance: