Appendix A
Children's Mental Health Clinics Co-Located in Primary Care Settings
Agency Transmittal Form
(Please attach as cover page on all copies of the proposal)

Agency Name: _____

Mailing Address:

Street: _____

City: _____ State: NY Zip Code: _____

Agency Information:

Federal Tax Exempt Identification Number: _____

New York State Charities Registration Number (if Applicable): _____

Contact Person:

Name: _____ Title: _____

E-mail: _____

Phone: _____ Fax: _____

CEO/Executive Director:

Name: _____ Title: _____

E-mail: _____

Phone: _____ Fax: _____

Region Choice:

Specify the region selected for implementation:

- ◯ Central
- ◯ New York City
- ◯ Hudson River
- ◯ Western
- ◯ Long Island

Proposal Components: The attached proposal contains the following:

Program Narrative	☐ Yes
Budget Form (Appendix B)	☐ Yes
Budget Narrative (Appendix B1)	☐ Yes
Satisfaction Survey for Primary Care Staff	☐ Yes
Satisfaction Survey for Service Recipients	☐ Yes
Letter of Support from Primary Care Practice	☐ Yes
Letter of Support from County	☐ Yes

_____

Signature of Person Completing Form

Title: _____ **Date:** _____