

**Appendix C**

**DIS AND PS SERVICES RFP  
PROPOSAL COVER SHEET**

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Phone Fax

\_\_\_\_\_  
Contact Person Title

\_\_\_\_\_  
Email

**Type of Agency:** (check one, only)  
\_\_\_\_ Not-for-profit 501(c) (3) \_\_\_\_ Local Health Department \_\_\_\_ Other \_\_\_\_\_

**Funding Request: \$** \_\_\_\_\_

\_\_\_\_\_  
Signature, Chairperson, Board of Directors

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name and Title

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name and Title