**REQUEST FOR PROPOSALS**

**RFP # DOC-RES/NON-RES-PS-2020-SM**

**Department of Correction**

**February 2020**

**FORM #2: Proposal Cover Sheet**

**Proposer’s Legal Name FEIN**

 (month) to (month)

**Address Proposer’s Fiscal Year:**

**City/Town State Zip Code**

**Contact Name:** **Title:**

**Telephone Number** **E-Mail Address**

**Total Annual Program Cost** **Total Annual Cost to CTDOC Requested Startup Costs**

*(not including startup)* (*not including startup)*

**Proposed Program Type:**

***Residential --***  [ ] Work Release [ ] Women &Children [ ] Substance Abuse [ ] Mental Health

[ ] Transitional Housing [ ] Scattered Site Supportive Housing [ ] Sex Offender [ ] Behavioral Intervention

[ ] Re-Housing [ ] Per Diem

***Non-Residential*** -- [ ] Fiduciary Services [ ] Employment Services/Educational/Vocational Coordinator

**Proposed Program Name:**

**Proposed Program Address:**

**Proposed # of Beds: Total Program # of Beds # of DOC Beds**

**Is your organization a non-profit?** Yes [ ]  No [ ]  **Is your organization incorporated?** Yes [ ]  No [ ]

**Is your organization registered as a:** Minority Business Enterprise? Yes [ ]  No [ ]

 Women Business Enterprise? Yes [ ]  No [ ]

 Small Business Enterprise? Yes [ ]  No [ ]

I certify that to the best of my knowledge and belief, the information contained in this proposal is true and correct. The proposal has been duly authorized by the governing body of the proposer, the proposer has the legal authority to apply for this funding, the proposer will comply with applicable state and federal laws and regulations, and that I am a duly authorized signatory for the proposer.

**Signature of Authorizing Official Date**

**Typed Name and Title**