**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**