**STATE OF CONNECTICUT**

#### OFFICE OF POLICY AND MANAGEMENT

#### OFFICE OF FINANCE

450 Capitol Avenue

MS# 54FIN

Hartford, CT 06106-1379

#### NOTICE OF 2015 GRANT AWARD

#### NONPROFIT GRANT PROGRAM (NGP)

|  |  |  |
| --- | --- | --- |
|  |  |  |

The Office of Policy and Management, Office of Finance, hereby makes the following grant award in accordance with Section 87 of Public Act 14-98, and in accordance with the grant solicitation and the attached grant application, if applicable.

Grantee Center for Medicare Advocacy, Inc.

Address PO Box 350

Address #2

City/State/Zip Willimantic, CT 06226

Town Code N/A

State Agency Code N/A

Federal Employer ID No. 06-1172509

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| OPM Grant No. 15OPM8001AJ | | | | | |
| Project Title I/T | | | | | |
| Date Of Award January 23, 2015 | | | | | |
| Period Of Award | | From: The day of the execution of the Notice of Grant Award by Grantor and Grantee. | | To: 1 year from the execution date by both Grantor and Grantee | |
| Amount Of Award | Federal: $ 0  State Match: $ 0 | | State: $ 18,680  Grantee Match: $ 0 | | Interest: $ 0  Other: Specify $ 0 |
| Total Budget $ 18,680 | | | | | |

|  |  |  |
| --- | --- | --- |
|  |  | CATALOG OF FEDERAL DOMESTIC ASSISTANCE |
| Federal Grant Number | N/A | (CFDA) Number N/A |
| Grantee Fiscal Year | From: July | To: June |

***My signature below, for and on behalf of the above named grantee, indicates acceptance of the above referenced award and further certifies that:***

1. I have the authority to execute this agreement on behalf of the grantee; and

2. The grantee will comply with all attached Grant Conditions.

BY: \_\_\_\_\_\_\_

Signature of Authorized Official

Judith Stein, Executive Director

Typed Name and Title of Authorized Official Date

|  |  |  |  |
| --- | --- | --- | --- |
| *FOR THE OFFICE OF POLICY AND MANAGEMENT BY*:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Signature of Authorized Official | Date | | |
| Benjamin Barnes, Secretary or Susan Weisselberg, Deputy Secretary | | |  |
| Typed Name and Title of Authorized Official |  | | |

***For OPM Business Office Use Only***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AMOUNT | DEPT | PROG | FUND | SID | ACCOUNT | PROJECT | CHART 1/2 | BR |
| $18,680.00 | OPM20830 | 13008 | 12052 | 43574 | 55050 | OPM000000001111 | 124113 | 2015 |

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**2015 NGP GRANT AWARD**

**PROJECT SUMMARY & CERTIFICATION FORM**

**GRANTEE NAME: Center for Medicare Advocacy, Inc.**

**PROJECT NAME: I/T**

**OPM GRANT NUMBER: 15OPM8001AJ**

**GRANTEE MAILING ADDRESS: PO Box 350**

**Willimantic, CT 06226**

**GRANTEE POINT OF CONTACT: Judith Stein**

**Email: Jstein@medicareAdvocacy.org Phone Number:**

|  |  |  |  |
| --- | --- | --- | --- |
| **PROJECT TYPE: Please mark the applicable box/boxes:** | | | |
| **Renovation/Improvement** | | **Energy Conservation** | **Information Technology** |
| **Safety** | **Electronic Medical Records** | | **Vehicles** |

**PROJECT DESCRIPTION: Please provide a brief description (300 words or less) of the project that the grant funds will be used for, including what type of service(s)/work for which the grant funds will be expended.**

**PROJECT BUDGET:**



Total of Components cannot exceed the maximum total award amount

**GRANTEE CERTIFICATION**

1. I am the representative of the provider (“Grantee”) listed above who is authorized to execute this form.
2. The above named project /grant award is in accordance with Section 13 of Public Act 13-239, the Notice of Grant Award, General Grant Conditions and NGP Grant Conditions.
3. The Grantee has authorized the project for which it will receive State of Connecticut funds.
4. The information contained on this form is true, accurate and complete.

***By (signature of authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Printed Name:*** Judith Stein ***Title:*** Executive Director

***Signed at , Connecticut, this day of 2015.***

***(town/city/or borough)***

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**FOR OPM USE:**

**Grant Administrator Name: Valerie Clark**

**Grant Administrator Phone: 860-418-6313**

**Grant Administrator Email: Valerie.clark@ct.gov**