

**APPENDIX E  
COVER PAGE**

**REQUEST FOR PROPOSALS - RFP # DOC-RES-2022-SM**

**Department of Correction**

*Due no later than November 5, 2021 – 3pm*

Proposer's Legal Name	FEIN		
Address:	Proposer's Fiscal Year ( <i>x month to x month</i> )		
		to	
City/Town	State	Zip Code	
Contact Name	Title		
Telephone Number	E-Mail Address		

FY22 Total Annual Program Cost (not including startup costs)	FY22 Requested Startup Costs (eligible for FY22 only)	FY22 Total Annual Cost to CTDOC (DOC Costs Only: Does not include other income from other sources)

**Proposed Program Type:**

**Residential --** ☐ Work Release ☐ Sub-Acute Mental Health

Proposed Program Name:	Proposed Program Address:	
Proposed Number 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.

<b>Signature of Authorizing Official</b>	<b>Date</b>

<b>Typed Name and Title</b>