## ATTACHMENT A: APPLICATION COVER

NORTH Dakota | Health & Human Services
Be Legendary.

### STATEWIDE HEALTH STRATEGIES GRANT APPLICATION COVER LETTER

| | |
|---|---|
| Organization Name | |
| Organization Type | |
| Mailing Address | |
| | |
| Primary Contact Person | |
| Title of Primary Contact | |
| Phone | |
| Email Address | |
| Business Officer Name | |
| Title | |
| Phone | |
| Email Address | |

Authorized Representative's Signature:_____

Printed Name:_____

Date:_____