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:_____