



## Community Application

Please provide the name and contact information for the primary person who will act on behalf of the proposing community in interactions with the State regarding this application.

### PRIMARY CONTACT INFORMATION

**Primary Contact:** \_\_\_\_\_

**Business Address:**

**Mailing Address:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Web Address (if applicable):** \_\_\_\_\_

# Coordinated System of Care Community Application

**APPLICATION MUST BE TYPED OR PRINTED LEGIBLY IN BLACK OR BLUE INK USING ARIAL 12 FONT.**

## Application Checklist:

- Completed List of Participating Community Partners
- Attached Letters of Support for EACH Community Partner
- Completed Primary Contact Information
- Completed Application Checklist
- Signed **Community Acceptance** Form
- Signed **WAA Lead Acceptance** Form
- Signed **FSO Lead Acceptance** Form
- Ten (10) duplicate copies of entire application packet



## Proposed WAA Agency Acceptance of WAA Requirements and Conditions

We, the undersigned, in our respective roles as chief executive and board chair of the agency proposed in this application to serve as the WAA in our local CSoC, certify to the following:

We each have read and understand the requirements related to the role of the WAA in Sections 3 and 4 of the CSoC RFA. We attest, individually and as an agency, that our agency is prepared to comply with all of the requirements included in Sections 3 and 4 of the CSoC RFA. We agree to fully implement the wraparound model with all the requirements and conditions listed within the application.

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

\_\_\_\_\_

Chief Executive Name / Title: \_\_\_\_\_

\_\_\_\_\_

Chief Executive Signature / Date: \_\_\_\_\_

Board of Directors Chairman Name / Title: \_\_\_\_\_

\_\_\_\_\_

Board of Directors Chairman Signature / Date: \_\_\_\_\_

\_\_\_\_\_

# Coordinated System of Care

## Community Application

### Proposed FSO Lead Acceptance of FSO Requirements and Conditions

We, the undersigned, in our respective roles as either (check one):

- (1) (a) chief executive and (b) board chair of the agency proposed in this application to serve as the FSO in our local CSoc OR
- (2) (a) individual leading the work group responsible locally for developing an FSO and (b) individual leading the work group responsible locally for developing the FSO's Local Coordinating Council (LCC) for our local CSoc

certify to the following:

We each have read and understand the requirements related to the role of the FSO and LCC in Sections 3 and 5 of the CSoc RFA. We attest, individually and, if applicable, as an agency, that our agency (if applicable) and community are prepared to comply with all of the requirements included in Sections 3 and 5 of the CSoc RFA. We agree to fully implement the FSO and LCC model with all the requirements and conditions listed within the application.

**Agency Name (if applicable):** \_\_\_\_\_

**Agency Address:** \_\_\_\_\_

**Chief Executive OR FSO Lead Name / Title:** \_\_\_\_\_

**Chief Executive / FSO Lead Signature / Date:** \_\_\_\_\_

**Board of Directors Chairman / LCC Lead Name / Title:** \_\_\_\_\_

**Board of Directors Chairman / LCC Lead Signature / Date:** \_\_\_\_\_

**\*Legal Note: This enrollment form confirms your desire to participate in the Coordinated System of Care.**

**Please submit all forms to:  
Coordinated System of Care Application  
Office of Behavioral Health  
P.O. Box XXXX**