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AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Rural Mental Health Integration Initiative
Cover Page

Applicant Organization:

Address:

Contact Name:

Contact email:

Contact phone:

Statement of Authorized Official
I affirm the following:
1) The contents of this application have been reviewed and approved by relevant organization leadership as well as the key stakeholders listed below.
2) Our organization meets the eligibility requirements described in Section 2 of the Request for Applications.
3) Our organization will participate fully in the training, implementation and impact evaluation activities described in Section 3 of the Request for Applications.
4) I understand the second payment of the award is contingent upon meeting participation requirements.
5) I understand grant funds are intended to offset the cost of clinic staff participation in planning, training and coaching activities described in Section 3 of the Request for Applications and are not intended to be used for clinical care delivery or other activities described in Section 4.D of the Request for Applications.

Prior Organization Participation
Has any clinic within this organization already received an award for participation in this initiative? ☐ Yes ☐ No

Organization Designation
Please indicate if your clinic is an RHC or an FQHC: ☐ RHC ☐ FQHC ☐ Neither

Authorized Official Name:

Authorized Official Signature: _____ Date: _____

Statement of Key Stakeholders
We affirm our support for participation in this initiative. Please include the Chief Medical Officer, Executive Director (or similar), Clinic Manager, Chief Financial Officer, at least one Primary Care Provider (in addition to CMO), Behavioral Health Director (if applicable), Psychiatric provider (if applicable), and others as relevant. Add additional lines as necessary.

Name	Role	Signature

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