ATTACHMENT A

MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HOMELESSNESS AND COORDINATED CARE

HOMELESSNESS SYSTEM OF CARE – STRATEGIC REFRESH

RFP-HHS-2026-14

Date: _____

Legal Applicant: Organization Name: Address: Telephone: E-mail: Contact Person: Contact Person's E-mail Address: Type of Organization (if Applicable): Date of Submission: **Federal Tax ID No.** **Funding Requested**
Certifications I certify that to the best of my knowledge the information contained in this application is accurate and complete and that I have the legal authority to commit this agency to a contractual agreement. I understand that final funding for any service is based upon funding levels and the approval of the Marin County Board of Supervisors. I further certify that the costs of the proposed project can be carried by the applicant for at least 60 days at any point during the term of the contract. Signature: Date: Name: Title:

For County Use Only

Date Received:	**Time Received:**
Marin County Staff Signature Acknowledging Receipt of Application:	