

Application for Federal Assistance SF-424

*** 1. Type of Submission:**

- ☐ Preapplication
☒ Application
☐ Changed/Corrected Application

*** 2. Type of Application:**

- ☒ New
☐ Continuation
☐ Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received:

Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:

Fort Bend County

* b. Employer/Taxpayer Identification Number (EIN/TIN):

766001969

* c. UEI:

d. Address:

* Street1:

301 Jackson Street

Street2:

* City:

Richmond

County/Parish:

* State:

Texas

Province:

* Country:

USA: UNITED STATES

* Zip / Postal Code:

77461

e. Organizational Unit:

Department Name:

Health & Human Services

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name:

Kaye

Middle Name:

* Last Name:

Reynolds

Suffix:

Title: Special Projects Coordinator

Organizational Affiliation:

Fort Bend County Health & Human Services

* Telephone Number:

832-535-9216

Fax Number:

281-238-3355

* Email:

Kaye.Reynolds@fortbendcountytx.gov

Application for Federal Assistance SF-424

* 9. Type of Applicant 1: Select Applicant Type:

County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

* 10. Name of Federal Agency:

Department of Health and Human Services

11. Catalog of Federal Domestic Assistance Number:

93.137

CFDA Title:

Community Programs to Improve Minority Health Grant Program

* 12. Funding Opportunity Number:

MP-CPI-22-005

* Title:

Promoting Equitable Access to Language Services in Health and Human Services

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Fort Bend County, Texas

Add Attachment

Delete Attachment

View Attachment

* 15. Descriptive Title of Applicant's Project:

LEP Language Access and Health Literacy

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant **22, 9**

* b. Program/Project **22, 9**

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment

Delete Attachment

View Attachment

17. Proposed Project:

* a. Start Date: **11/1/2022**

* b. End Date: **10/31/2025**

18. Estimated Funding (\$): \$1,125,000 (\$375,000 for three years)

* a. Federal	\$1,125,000
* b. Applicant	\$0
* c. State	\$0
* d. Local	\$0
* e. Other	\$0
* f. Program Income	\$0
* g. TOTAL	<input type="text"/>

* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?

- ☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .
- ☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- ☐ c. Program is not covered by E.O. 12372.

* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment

Delete Attachment

View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

☐ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: **KP**

Middle Name:

* Last Name: **George**

Suffix:

* Title: **County Judge**

* Telephone Number: **281-341-8608** Fax Number: **832-471-1858**

* Email: **county.judge@fortbendcountytexas.gov**

* Signature of Authorized Representative: * Date Signed: