CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) DIVISION

FUNDING AGREEMENT PERIOD
FY 2024-2025

AGENCY INFORMATION FORM

Agencies are required to submit an electronic and signed copy (original signatures only) of this form along with their Annual AFA Package.

Agencies are required to submit updated information when updates occur during the fiscal year. Updated submissions do not require certification signatures.

AGENCY IDENTIFICATION INFORMATION

Any program related information being sent from the CDPH MCAH Division will be directed to all Program Directors.

Please enter the agreement or contract number for each of the applicable programs

MCAH_____ BIH_____ AFLP_____ PEI_____

Update Effective Date *(only required when submitting updates)* _____

Federal Employer ID#:_____

Complete Official Agency Name:_____

Business Office Address:_____

Agency Phone:_____

Agency Fax:_____

Agency Website:_____

AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION

Please enter the **agreement or contract** number for each of the applicable programs

MCAH_____ BIH_____ AFLP_____ PEI_____

The undersigned hereby affirms that the statements contained in the Agreement Funding Application (AFA) are true and complete to the best of the applicant's knowledge.

I certify that these Maternal, Child and Adolescent Health (MCAH) programs will comply with all applicable provisions of Article 1, Chapter 1, Part 2, Division 106 of the Health, and Safety code (commencing with section 123225), Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 142), and any applicable rules or regulations promulgated by CDPH pursuant to this article and these Chapters. I further certify that all MCAH related programs will comply with the most current MCAH Policies and Procedures Manual, including but not limited to, Administration, Federal Financial Participation (FFP) Section. I further certify that the MCAH related programs will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Service Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. section 701 et seq.). I further agree that the MCAH related programs may be subject to all sanctions, or other remedies applicable, if the MCAH related programs violate any of the above laws, regulations, and policies with which it has certified it will comply.

Official authorized to commit the Agency to an MCAH Agreement

Name (Print) Title

_____ _____

Original Signature Date

_____ _____

MCAH/AFLP Director

Name (Print) Title

_____ _____

Original Signature Date

_____ _____

MCAH Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							MCAH
2	MCAH DIRECTOR							MCAH
3	MCAH COORDINATOR (Only complete if different from #2)							MCAH
4	MCAH FISCAL CONTACT							MCAH
5	FISCAL OFFICER							MCAH
6	CLERK OF THE BOARD or							MCAH
7	CHAIR BOARD OF SUPERVISORS							MCAH
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY							MCAH
9	SUDDEN INFANT DEATH SYNDROME (SIDS) COORDINATOR/CONTACT							SIDS
10	PERINATAL SERVICES COORDINATOR							CPSP

BIH Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							BIH
2	BLACK INFANT HEALTH (BIH) COORDINATOR							BIH
3	BIH FISCAL CONTACT							BIH
4	FISCAL OFFICER							BIH
5	CLERK OF THE BOARD or							BIH
6	CHAIR BOARD OF SUPERVISORS							BIH
7	OFFICIAL AUTHORIZED TO COMMIT AGENCY							BIH

PEI

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							PEI
2	PERINATAL EQUITY INITIATIVE (PEI) COORDINATOR							PEI
3	PEI FISCAL CONTACT							PEI
4	FISCAL OFFICER							PEI
5	CLERK OF THE BOARD or							PEI
6	CHAIR BOARD OF SUPERVISORS							PEI
7	OFFICIAL AUTHORIZED TO COMMIT AGENCY							PEI

AFLP Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							AFLP
2	AFLP DIRECTOR							AFLP
3	AFLP COORDINATOR or SUPERVISOR/COORDINATOR							AFLP
4	AFLP FISCAL CONTACT							AFLP
5	FISCAL OFFICER							AFLP
6	CLERK OF THE BOARD or							AFLP
7	CHAIR BOARD OF SUPERVISORS							AFLP
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY							AFLP