

CITY OF AKRON – AGENCY-ORGANIZATION CONTACT INFORMATION

PROGRAM: Emergency Solutions Grant (ESG) Program PROGRAM YEAR: 2024

Agency Name: _____

Program Name: _____

Date Form Completed: _____ Program Dates: _____

Agency Mailing Address: _____

Agency Phone No.: _____ Agency Website: _____

Agency Federal Tax Identification Number: _____ (REQUIRED)

Agency SAM Unique Entity ID (UEI): _____ (REQUIRED)

Year Incorporated: _____ (REQUIRED) 501(c)(3) Status: Yes _____ No _____ (REQUIRED)

CONTACT INFORMATION

Agency's Authorized Signee Name: _____

Title: _____

Phone No. (and/or Ext.): _____ Email Address: _____

Additional Agency Contact Person(s) – Include staff(s) that submit invoices and staff(s) responsible for HMIS.

Name: _____ Title or Duty: _____

Phone No. (and/or Ext.): _____ Email Address: _____

Name: _____ Title or Duty: _____

Phone No. (and/or Ext.): _____ Email Address: _____

Name: _____ Title or Duty: _____

Phone No. (and/or Ext.): _____ Email Address: _____

Name: _____ Title or Duty: _____

Phone No. (and/or Ext.): _____ Email Address: _____

Name: _____ Title or Duty: _____

Phone No. (and/or Ext.): _____ Email Address: _____

Name: _____ Title or Duty: _____

Phone No. (and/or Ext.): _____ Email Address: _____

*If additional Contact Person(s) lines are needed, attach a 2nd sheet

Please email completed form to:

Dcool@akronohio.gov

&

Dchambers@akronohio.gov

Date Received: _____

Processed: _____