**Attachment 1**

**Application Cover Page**

**Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services – Reissue**

**RFA #24-0003**

**(When completing the information below, please type all information)**

**Applicant Organization Name:**

**Contact Person:**

**Title:**

**Address:**

**Telephone #:**

**Fax #:**

**Email Address:**

**Provider Type:**

**Federal ID Number:**

**Unique Entity Identifier (UEI):**

**Annual Requested Amount:**

**Component Applying for:**

**New York State Department of Health Region:**

**Name and Address of Proposed Funding Site:**

**Name of Authorized Official:**

**Signature of Authorized Official:**