**STATE OF CONNECTICUT | OFFICE OF POLICY AND MANAGEMENT**

**OFFICE OF FINANCE**

450 Capitol Avenue | MS# 54FIN | Hartford, CT 06106-1379

**NOTICE OF GRANT AWARD**

The Office of Policy and Management, **Office of Finance**, hereby makes the following grant award

in accordance with Public Act 14-98, Section 87 and in accordance with the grant solicitation and the attached grant application, if applicable.

|  |  |
| --- | --- |
| Grantee: Fair Haven Community Health Clinic, Inc. | Town Code: N/A |
| Street address: 374 Grand Avenue  | State Agency Code: N/A | DUNS No. (if applicable): N/A |
| City: New Haven | State: CT | ZIP Code: 06513 | FEIN (required): 06-0883545 |
| Grant Program Name: NONPROFIT GRANT PROGRAM |  |
| OPM Grant No.: 16OPM8002AP | Project Title: I/T Enhancements |
| Date of Award: February 10, 2016 | Category (if applicable): N/A  |
| Period of Award: (Choose one)Start Date: [x]  The date Notice of Grant Award is signed by both Grantor & Grantee (whichever is later).  [ ]  On **Select Date** or after Notice of Grant Award is signed by both parties (whichever is later). [ ]  **Select Date** pursuant to **Enter Statutory Authority** *(attach copy of authority w/ notice of grant award).*  | End Date: **One year from the execution of grant award by both grantor and grantee.** |
| Amount of Award: $120,875 | Federal: $ N/A | State: $120,875 |  Interest: $ N/A |
| State Match: $ N/A | Grantee Match:  | Other: $ N/A Specify: N/A |
| Total Budget: $120,875 | Catalog of Federal Domestic Assistance (CFDA) Number: N/A |
| Federal Grant No.: N/A | Grantee Fiscal Year: From: To:  |
| My signature below, for and on behalf of the above named grantee, indicates acceptance of the above referenced award and further certifies that: 1.) I have the authority to execute this agreement on behalf of the grantee; and 2.) The grantee will comply with all attached Grant Conditions. **BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Signature of Authorized Grantee Official Date** **Suzanne Lagarde, CEO****FOR THE OFFICE OF POLICY AND MANAGEMENT:****BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Signature of OPM Secretary or OPM Deputy Secretary Date** **Benjamin Barnes, Secretary or Susan Weisselberg, Deputy Secretary** |
| **For OPM Business Use Only** |  |
| **AMOUNT** | **FUND** | **DEPT** | **SID** | **PROG** | **ACCT** | **CHART 1** | **CHART 2** | **BR YR** | **PROJECT** |
| **$120,875** | **12052** | **OPM 20830** | **43574** | **13008** | **55050** | **124113** |  | **2016** | **OPM000000001111** |
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OFFICE OF POLICY AND MANAGEMENT

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**2016 NGP GRANT AWARD**

**PROJECT SUMMARY & CERTIFICATION FORM**

**GRANTEE NAME: Fair Haven Community Health Clinic, Inc.**

**PROJECT NAME: I/T Enhancements**

**OPM GRANT NUMBER: 16OPM8002AP**

**GRANTEE MAILING ADDRESS: 374 Grand Avenue**

 **New Haven, CT 06513**

**GRANTEE POINT OF CONTACT: Suzanne Lagarde**

**Email: s.lagarde@fhchc.org Phone Number:**

|  |
| --- |
| **PROJECT TYPE: Please mark the applicable box/boxes:** |
| **Renovation/Improvement [ ]**  | **Energy Conservation [ ]**  |  **Information Technology [ ]**  |
| **Safety [ ]**  | **Electronic Medical Records [ ]**  | **Vehicles/Generator [ ]**  |
| **New Construction [ ]**  | **Property Acquisition [ ]**  |  |

**PROJECT DESCRIPTION: Please provide a brief description (300 words or less) of the project that the grant funds will be used for, including what type of service(s)/work for which the grant funds will be expended.**

**PROJECT BUDGET:**



 Total of Components cannot exceed the maximum total award amount

**GRANTEE CERTIFICATION**

1. I am the representative of the provider (“Grantee”) listed above who is authorized to execute this form.
2. The above named project /grant award is in accordance with Section 87 of Public Act 14-98, the Notice of Grant Award, General Grant Conditions and NGP Grant Conditions.
3. The Grantee has authorized the project for which it will receive State of Connecticut funds.
4. The information contained on this form is true, accurate and complete.

***By (signature of authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***Printed Name:*** Suzanne Lagarde ***Title:*** CEO

***Signed at , Connecticut, this day of 20 .***

 ***(town/city/or borough)***

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**FOR OPM USE:**

**Grant Administrator Name: Valerie Clark**

**Grant Administrator Phone: 860-418-6313**

**Grant Administrator Email: Valerie.clark@ct.gov**