

**Application for Federal Assistance SF-424**

* 1. Type of Submission: <input type="radio"/> Preapplication <input checked="" type="radio"/> Application <input type="radio"/> Changed/Corrected Application	* 2. Type of Application: * If Revision, select appropriate letter(s): <input checked="" type="radio"/> New <input type="radio"/> Continuation <input type="radio"/> Revision	<input type="text"/> * Other (Specify) <input type="text"/>
---	--	---

* 3. Date Received: <input type="text" value="09/30/2024"/>	4. Applicant Identifier: <input type="text" value="GJeffrey"/>
--	---

5a. Federal Entity Identifier: <input type="text"/>	5b. Federal Award Identifier: <input type="text"/>
--	---

**State Use Only:**

6. Date Received by State: <input type="text"/>	7. State Application Identifier: <input type="text"/>
---	---

**8. APPLICANT INFORMATION:**

\* a. Legal Name:

* b. Employer/Taxpayer Identification Number (EIN/TIN): <input type="text" value="59-6000800"/>	* c. UEI: <input type="text" value="R37RMC63XKG1"/>
--	--

**d. Address:**

\* Street1:   
Street2:   
\* City:   
County/Parish:   
\* State:   
Province:   
\* Country:   
\* Zip / Postal Code:

**e. Organizational Unit:**

Department Name: <input type="text"/>	Division Name: <input type="text"/>
--	--

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

Prefix:  \* First Name:   
Middle Name:   
\* Last Name:   
Suffix:

Title:

Organizational Affiliation:

\* Telephone Number:  Fax Number:

\* Email:

**Application for Federal Assistance SF-424**

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

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

\* Other (specify):

**\* 10. Name of Federal Agency:**

Substance Abuse and Mental Health Services Adminis

**11. Catalog of Federal Domestic Assistance Number:**

93.243

CFDA Title:

Substance Abuse and Mental Health Services Projects of Regional and National Significance

**\* 12. Funding Opportunity Number:**

TI-24-004

\* Title:

Grants to Expand Substance Use Disorder Treatment Capacity in Adult and Family Treatment Drug Courts

**13. Competition Identification Number:**

TI-24-004

Title:

SAMHSA Treatment Drug Courts

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

File Name:

**\* 15. Descriptive Title of Applicant's Project:**

Pinellas Drug Dependency Court Expansion

Attach supporting documents as specified in agency instructions.

File Name:

**Application for Federal Assistance SF-424**

**16. Congressional Districts Of:**

\* a. Applicant

\* b. Program/Project:

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

File Name: 2022WebMapCONGRESS\_BW.pdf

**17. Proposed Project:**

\* a. Start Date:

\* b. End Date:

**18. Estimated Funding (\$):**

* a. Federal	<input type="text" value="400,000.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="400,000.00"/>

**\* 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

**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:   
Middle Name:   
\* Last Name:   
Suffix:

\* Title:

\* Telephone Number:  Fax Number:

\* Email:

\* Signature of Authorized Representative:  \* Date Signed:

**APPROVED AS TO FORM**  
By: Cody J. Ward  
Office of the County Attorney