**Attachment 5**

Applicant Information Form

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| **South Carolina Department of Public Health****Ryan White Part B Program Funding** **Applicant Information Form****2025-2026 Grant Year** |
| **Instructions:** Please complete this form in its entirety and upon submission, please attach a W9. |
| **Name of Organization:** |  |
| **Address:** |  | **State:** |  | **Zip:** |  |
| **Phone:** |  | **Fax:** |  | **Web Address:** |  |
| **Tax/Employer ID:** |  | **Unique Entity ID:** |  |
| **Vendor Number:** |  |
| **Remittance Address:** Address must match the address used for vendor registration.  |
| **Name of Organization:** |  |
| **Business Mailing Address:** |  |
| **Primary Contact:** |  | **Phone:** |  |
| **Email:** |  |
| **Performance:** If awarded, please provide the requested information below of all sites where Ryan White Part B Program services will be provided. |
| **Principle Place of Performance Site 1** |
| **Name of Organization:** |  |
| **Physical Address:** |  |
| **Performance Site 2, if applicable** |
| **Name of Organization:** |  |
| **Physical Address:** |  |
| **Performance Site 3, if applicable** |
| **Name of Organization:** |  |
| **Physical Address:** |  |
| **Business Entity** |
| **Please choose they type of business Entity:*** Corporation
* LLC
* Partnership
* Nonprofit Organization
* Government Agency or Political Subdivision, specify state if not SC: \_\_\_\_\_\_\_\_\_\_\_\_
* Other Governmental Body
* Individual / Sole Proprietor
* Other
 | If **“Other Governmental Body”** Specify:  | **If a Corporation, LLC, or Nonprofit Organization, please provide the following information below.**State of Incorporation:  |
| If **“Other”** Specify: | Registered Agent and Address in South Carolina: |
| **SC DLLR or any other License Number (If applicable):** |  |
| **Does your agency have a Federally Negotiated Indirect Cost Rate?**If yes, please attach a copy of the Federally Negotiated Indirect Cost Rate Agreement. This information must be received with your application. Note, indirect costs are considered administration cost. For the HOPWA Program these costs are capped at 7%.  | **Yes** |  | **No** |  |
| **Primary Contacts** |
| **Contract Signatory** |
| **Name:** |  | **Title:** |  |
| **Business Mailing Address:** |  |
| **Phone:** |  | **Fax:** |  |
| **Email:** |  |
| **Program Director** |
| **Name:** |  | **Title:** |  |
| **Business Mailing Address:** |  |
| **Phone:** |  | **Fax:** |  |
| **Email:** |  |
| **Financial Director** |
| **Name:** |  | **Title:** |  |
| **Business Mailing Address:** |  |
| **Phone:** |  | **Fax:** |  |
| **Email:** |  |