

SIGNATURE PAGE

CC-15-2024

To the Monmouth County Board of County Commissioners:

**THE UNDERSIGNED HEREBY DECLARES THAT
I (WE) HAVE CAREFULLY EXAMINED THE SPECIFICATIONS.
I (WE) HEREBY CERTIFY PRICES QUOTED ARE IN ACCORDANCE
WITH YOUR REQUIREMENTS.**

Company Name: Hope Sheds Light

Preparer's Name: Pamela Capaci (PRINT)

Signature: [Handwritten Signature] (PRINT) (DATE)

Address: 2570 Apache Rd
Manasquan, NJ 08736

Telephone No.: 732-244-0783 ext. 101

Fax No.: _____

E-Mail Address: pam@hopeshedslight.org

*** (This should be the email where Contracts would be sent) ***

Contact Person: Pamela Capaci

FEIN: _____
(Federal Employee ID)

BRC: _____
(Business Registration Certificate)

**MONMOUTH COUNTY DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH
APPLICATION FOR 2024 COUNTY GRANT FUNDS**

Service Type: Treatment Prevention Recovery Support **Innovation**
 Circle (1)

Innovation Family to Family

(Insert Service Modality being applied for in the box above)

Hope Sheds Light

1. Name of Contractor				
2510 Apache Rd	Manasquan	Monmouth	NJ	08736
2. Street Address	City	County	State	Zip Code

Barbara Hoopengardner, Finance Director 732-244-0783 ext. 120

3. Name and Title of Fiscal Contact	Telephone No.
Pamela Capaci, CEO	732-244-0783 ext. 101
4. Name and Title of Director	Telephone No.
Emily Hendricks, Program Director	732-244-0783 ext. 121
5. Name and Title of Program Manager/Medical Director	Telephone No.
N/A	

6. Employer ID No.	NJ State License No., if Applicable	Accreditations
N/A	N/A	N/A

1. Location of Proposed Project	City	County	State	Zip Code
2510 Apache Rd.	Manasquan	Monmouth	NJ	08736

7. Total Proposed Level of Service in 2024	9. Unit of Service Cost in 2024

10. Type of Agency (check one)
 PRIVATE NON-PROFIT GOVERNMENT HOSPITAL Other (specify)

11. If political subdivision, covered by NJ Civil Service Merit System?	12. Affirmative Action Plan	13. If grant is awarded, will funds be used to replace other funds which would be available in absence of award?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

14. Total Funds Requested **\$100,000.00** **COST OF PROJECT** *8100,000.00*

Certification: The undersigned assures, declares and certifies that to the best of his/her knowledge and belief, all information contained in this application and attachments are true and correct, the application has been duly authorized by the governing body of the Contractor and the services described herein will be provided to the extent agreed upon in the contract developed as a result of this application. The undersigned further understands and agrees that any grant received as a result of this application shall be subject to the conditions and other policies, regulations and rules issued by the County of Monmouth for the administration of grants which include provisions described in the grant application. In addition, the undersigned gives permission to the Division of Behavioral Health to contact State, County and Federal agencies as well as charitable funding sources to discuss and share relevant financial, budget, programmatic and contract information. The undersigned also agrees to make available to the Division upon request, the organization's budget and fiscal audit.

<i>Pamela Capaci, CEO</i>		
NAME AND TITLE OF CONTRACTOR (Print)	SIGNATURE OF CONTRACTOR	DATE OF APPLICATION
Hope Sheds Light	<i>[Signature]</i>	4/27/24

**MONMOUTH COUNTY DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH
APPLICATION FOR 2024 COUNTY GRANT FUNDS**

Service Type: Treatment Prevention **Recovery Support** Innovation
Circle (1)

Recovery Support

(Insert Service Modality being applied for in the box above)

Hope Sheds Light

1. Name of Contractor				
2510 Apache Rd	Manasquan	Monmouth	NJ	08736
2. Street Address		City	County	State Zip Code
Barbara Hoopengardner, Finance Director			732-244-0783 ext.120	
3. Name and Title of Fiscal Contact			Telephone No.	
Pamela Capaci, CEO			732-244-0783 ext. 101	
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Emily Hendricks, Program Director			732-244-0783 ext.121	
5. Name and Title of Program Manager/Medical Director			Telephone No.	
6. Employer ID No.			NJ State License No., if Applicable	
			Accreditations	

1. Location of Proposed Project	City	County	State	Zip Code
2510 Apache Rd.	Manasquan	Monmouth	NJ	08736

8. Total Proposed Level of Service in 2024	9. Unit of Service Cost in 2024
10. Type of Agency (check one)	
<input checked="" type="checkbox"/> PRIVATE NON-PROFIT <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Other (specify)	

11. If political subdivision, covered by NJ Civil Service Merit System?	12. Affirmative Action Plan	13. If grant is awarded, will funds be used to replace other funds which would be available in absence of award?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<input type="checkbox"/> X YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

14. Total Funds Requested **\$25,000.00** **COST OF PROJECT** *\$ 25,000.00*

Certification: The undersigned assures, declares and certifies that to the best of his/her knowledge and belief, all information contained in this application and attachments are true and correct, the application has been duly authorized by the governing body of the Contractor and the services described herein will be provided to the extent agreed upon in the contract developed as a result of this application. The undersigned further understands and agrees that any grant received as a result of this application shall be subject to the conditions and other policies, regulations and rules issued by the County of Monmouth for the administration of grants which include provisions described in the grant application. In addition, the undersigned gives permission to the Division of Behavioral Health to contact State, County and Federal agencies as well as charitable funding sources to discuss and share relevant financial, budget, programmatic and contract information. The undersigned also agrees to make available to the Division upon request, the organization's budget and fiscal audit.

NAME AND TITLE OF CONTRACTOR (Print)	SIGNATURE OF CONTRACTOR	DATE OF APPLICATION
Hope Sheds Light	<i>Pamela Capaci</i>	4/27/24