**Application Form**

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| **Funding Amount Requested** | $ |

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| --- | --- | --- | --- |
| **Contact Information\*** | | | |
| **Applicant Name** |  | **Name of Project**  **Coordinator** |  |
| **Contact Person, Title** |  | **Contact Person, Title** |  |
| **Address** |  | **Address** |  |
| **Phone #** |  | **Phone #** |  |
| **Fax #** |  | **Fax #** |  |
| **Email Address** |  | **Email Address** |  |

\*This is who will be contacted if awarded to negotiate the work plan and budget.

Please be sure to complete all sections below, including signing the attestation, before submitting.

**Applicant Information:**

Please provide the information requested below.

1. The number of clinics and the include the location(s), including street address and county, of clinic(s) or professional office(s) of the applicant where abortion services will be provided.

Number of Clinics:

Address of Primary Clinic:

Addresses of Additional Clinics (if applicable):

1. Number of clinical providers who are currently performing medical and/or procedural abortions.

Number of clinical providers currently performing abortion:

1. The number of medical abortions provided in calendar years 2017, 2018, 2019, 2020, and 2021, and if available from 7/1/21-6/30/22.

|  |  |
| --- | --- |
| Time Period | Number of Medical Abortions Provided\* |
| Calendar Year 2017 |  |
| Calendar Year 2018 |  |
| Calendar Year 2019 |  |
| Calendar Year 2020 |  |
| Calendar Year 2021 |  |
| 7/1/2021-6/30/22 (if available) |  |

\* Enter a whole number. If the abortion service was not provided, enter 0.

1. The number of procedural abortions provided in calendar years 2017, 2018, 2019, 2020, and 2021, and if available from 7/1/21-6/30/22.

|  |  |
| --- | --- |
| Time Period | Number of Procedural Abortions Provided\* |
| Calendar Year 2017 |  |
| Calendar Year 2018 |  |
| Calendar Year 2019 |  |
| Calendar Year 2020 |  |
| Calendar Year 2021 |  |
| 7/1/21-6/30/22 |  |

\* Enter a whole number. If the abortion service was not provided, enter 0.

1. The anticipated increase in the number of medical and/or procedural abortion access that could be made available with the funding. **This information is required and cannot be left blank and cannot be 0.**

Anticipated/Estimated Increase:

**Project Narrative:**

Please provide a brief description of how the funding will be used to expand access to abortion services, and include information about any impact the Supreme Court ruling has had (e.g., increase in number of referrals and/or appointments):

**Attestation:**

Please complete, enter the organization’s legal name, and information required below, and sign the attestation before submitting.

**Funding Opportunity:** Expanding Safe and Supportive Medical and/or Procedural Abortion Access in New York State Phase Two

**Organization:** «Enter Organization's Legal Name»

**Contract Term:**  1/1/2023 - 12/31/2023

Consistent with the Solicitation of Interest for the above referenced funding opportunity and the information provided through the application cover page, the individual authorized by the above-named organization to submit this form attests that the information submitted is accurate and attests that the funding will be used to expand access to abortion services. If the information is determined to be inaccurate, the Department can adjust the contract award amount or terminate the contract if needed. The individual authorized by the above-name organization attests to the organization’s willingness to enter into a binding Master Grant Contract with NYSDOH without change or amendment.

Name of Person Authorized to Attest: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Electronic Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The completed and signed attestation must be included with the application.

Any questions should be sent to nysabortionaccess@health.ny.gov.