Behavioral Health Student Services Act
Substance Use Disorder Services and Supports
Round 2: Sub-Grantee Authorized Signatory (Attachment F)

TRI·CITY Mental Health

Name of agency/organization:

Address: Website:

BHSSA SUD Sub-Grant Project:

Completion of this form establishes that the person(s) identified below has the authority to affirm that records corresponding to the Behavioral Health Student Services Act (BHSSA) Substance Use Disorder (SUD) sub-grant applicant organization and project are full, true, and correct and describe fully, truly, and accurately any work performed and any amounts listed related to the BHSSA SUD sub-grant project.

To affirm signatory authorization and/or to delegate signatory authorization, identify the person(s) below and provide corresponding signatures. If authorization changes during the BHSSA SUD sub-grant project period, this form must be resubmitted with updated information.

Authorized Representative

The authorized representative is the individual authorized to enter into, sign, and execute a contract agreement on behalf of the applicant organization.

Full Name (First, Last): Title:

Email: Phone Number:

Signature: Date:

Approved Authorized Signatory (up to three individuals)

The following named person/(s) is/(are) authorized to serve as signatory/(ies) of the applicant organization and to act on behalf of the applicant organization in affirming BHSSA SUD sub-grant project related records.

Full Name (First, Last): Title:

Email: Phone Number:

Signature: Date:

Full Name (First, Last): Title:

Email: Phone Number:

Signature: Date:

Full Name (First, Last): Title:

Email: Phone Number:

Signature: Date: