Appendix A

Submission Required

See due date below

CONTINUATION SOLICITATION REIMBURSEMENT TYPE FORM

Ohio Department of Health

Office of Medical Director

Bureau of Child and Family Health

*ODH Program Title:*

Reproductive Health and Wellness Program – RH25

Appendix A

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**Reimbursement Type (check one)** Monthly **OR** Quarterly

(Please note that no changes to the reimbursement type can be made after the project number is created in GMIS. No waivers/appeals will be accepted.)

*Please print:*

Current Project Number

Applicant Agency/Organization

Applicant Agency Address

Agency Contact Person Name and Title

Telephone Number

E-mail Address

Agency Head (Print Name) Agency Head (Signature)

*Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF’s will not be accepted if name doesn’t match what is listed in GMIS.*

Due to ODH by November 1, 2023.

Please email completed form to Maria Kapenda (Maria.Kapenda@odh.ohio.gov).