

**CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) DIVISION**

**FUNDING AGREEMENT PERIOD
FY 2010-11 to 2012-13 (LHJs) / FY 2005-06 to 2011-12 (CBOs)**

AGREEMENT FUNDING APPLICATION (AFA)/UPDATE FORM *

At the beginning of each fiscal year Agencies are required to submit this AFA Form along with their AFA Package, which requires certification signatures (original signatures, no stamps allowed). This form should also be used when submitting updates that occur during the fiscal year. Update submissions do not require certification signatures.

The Agency Identification Information section must be completed each time this form is submitted.

* Note: Agreement refers to Allocations for LHJs or Grants for CBOs.

AGENCY IDENTIFICATION INFORMATION

Any program related information being sent from the CDPH MCAH Division
will be directed to the MCAH and/or AFLP Director.

Please check the applicable "Program" boxes below and provide the "Fiscal Year" of the changes being submitted: MCAH AFLP BIH FIMR

Fiscal Year: 2010-2011 Update Effective: _____ (only required when submitting updates)

Agreement Number:	2010-09		
Federal Employer ID#:	94-6000511		
Complete Official Agency Name:	COUNTY OF EL DORADO HEALTH SERVICES DEPARTMENT PUBLIC HEALTH DIVISION		
Business Office Address:	929 SPRING STREET PLACERVILLE, CA 95667		
Agency Phone:	(530) 621-6100	Agency Fax:	(530) 642-0892
Agency Website Address:	www.edcgov.us/publichealth		

1 AGENCY DIRECTOR

Name:	NEDA WEST				
Title:	DIRECTOR, HEALTH SERVICES				
Mailing Address:	931 SPRING STREET				
City:	PLACERVILLE, CA	Zip:	95667		
Phone:	(530) 621-6149	Ext.		FAX:	(530) 626-4713
E-Mail Address:	neda.west@edcgov.us				

2 BOARD INFORMATION					
Clerk of the Board <input type="checkbox"/>			Chair Board of Supervisors <input checked="" type="checkbox"/>		
Title:	COUNTY OF EL DORADO BOARD OF SUPERVISORS				
Mailing Address:	330 FAIR LANE, BLDG A				
City:	PLACERVILLE	Zip:	95667		
Phone:	(530) 621-5390	Ext.		FAX:	(530) 622-3645
E-Mail Address:	www.bos@edcgov.us				

3 OFFICIAL AUTHORIZED TO COMMIT AGENCY					
Name:	NEDA WEST				
Title:	DIRECTOR, HEALTH SERVICES				
Mailing Address:	931 SPRING STREET				
City:	PLACERVILLE, CA	Zip:	95667		
Phone:	(530) 621-6149	Ext.		FAX:	(530) 626-4713
E-Mail Address:	neda.west@edcgov.us				

4 FISCAL OFFICER					
Name:	TARA FILIPCH				
Title:	ADMINISTRATIVE SERVICES OFFICER				
Mailing Address:	941 SPRING STREET				
City:	PLACERVILLE, CA	Zip:	95667		
Phone:	(530) 621-6302	Ext.		FAX:	(530) 642-8159
E-Mail Address:	tara.filipich@edcgov.us				

5 MCAH DIRECTOR (Please check box if MCAH and AFLP Director are the same) <input type="checkbox"/>					
Name:	PHYLLIS GOLDIE				
Title:	SUPERVISING PUBLIC HEALTH NURSE				
Mailing Address:	929 SPRING STREET				
City:	PLACERVILLE, CA	Zip:	95667		
Phone:	(530) 621-6185	Ext.		FAX:	(530) 642-0892
E-Mail Address:	phyllis.goldie@edcgov.us				

6 MCAH COORDINATOR (Only list if different from previous)						
Name:						
Title:						
Mailing Address:						
City:				Zip:		
Phone:			Ext.			
E-Mail Address:						

7 MCAH BUDGET CONTACT						
Name:	LAURIE MILLMAN					
Title:	ACCOUNTANT					
Mailing Address:	941 SPRING STREET					
City:	PLACERVILLE			Zip:	95667	
Phone:	(530) 621-6124		Ext.			
E-Mail Address:		Barry.price@edcgov.us				

8 MCAH INVOICE CONTACT (Only list if different from above)						
Name:						
Title:						
Mailing Address:						
City:				Zip:		
Phone:			Ext.			
E-Mail Address:						

9 PERINATAL SERVICES COORDINATOR (PSC)						
Name:	PATRICIA MURPHY					
Title:	PUBLIC HEALTH NURSE II					
Mailing Address:	1360 JOHNSON BLV, SUITE 103					
City:	SOUTH LAKE TAHOE, CA			Zip:	96150	
Phone:	(530) 573-3049		Ext.			
E-Mail Address:		patty.murphy@edcgov.us				

10 PRENATAL CARE GUIDANCE (PCG) COORDINATOR					
Name:	PATRICIA MURPHY				
Title:	PUBLIC HEALTH NURSE II				
Mailing Address:	1360 JOHNSON BLV, SUITE 103				
City:	SOUTH LAKE TAHOE, CA			Zip:	96150
Phone:	530) 573-3049	Ext.		FAX:	(530) 543-6819
E-Mail Address:	patty.murphy@edcgov.us				

11 AFLP DIRECTOR (Only list if different from MCAH Director)					
Name:					
Title:					
Mailing Address:					
City:				Zip:	
Phone:		Ext.		FAX:	
E-Mail Address:					

12 AFLP COORDINATOR (Only list if different from above)					
Name:					
Title:					
Mailing Address:					
City:				Zip:	
Phone:		Ext.		FAX:	
E-Mail Address:					

13 AFLP BUDGET CONTACT					
Name:					
Title:					
Mailing Address:					
City:				Zip:	
Phone:		Ext.		FAX:	
E-Mail Address:					

14 AFLP INVOICE CONTACT (Only list if different from previous)								
Name:								
Title:								
Mailing Address:								
City:				Zip:				
Phone:			Ext.			FAX:		
E-Mail Address:								

15 BLACK INFANT HEALTH (BIH) COORDINATOR								
Name:								
Title:								
Mailing Address:								
City:				Zip:				
Phone:			Ext.			FAX:		
E-Mail Address:								

16 BIH BUDGET CONTACT								
Name:								
Title:								
Mailing Address:								
City:				Zip:				
Phone:			Ext.			FAX:		
E-Mail Address:								

17 BIH INVOICE CONTACT (Only list if different from above)								
Name:								
Title:								
Mailing Address:								
City:				Zip:				
Phone:			Ext.			FAX:		
E-Mail Address:								

18 FETAL INFANT MORTALITY REVIEW (FIMR) COORDINATOR

Name:								
Title:								
Mailing Address:								
City:				Zip:				
Phone:			Ext.			FAX:		
E-Mail Address:								

19 SUDDEN INFANT DEATH SYNDROME (SIDS) COORDINATOR/CONTACT

Name:	PHYLLIS GOLDIE							
Title:	SUPERVISING PUBLIC HEALTH NURSE							
Mailing Address:	929 SPRING STREET							
City:	PLACERVILLE, CA			Zip:	95667			
Phone:	(530) 621-6185		Ext.			FAX:	(530) 642-0892	
E-Mail Address:	phyllis.goldie@edcgov.us							

20 OTHER

Name:								
Title:								
Mailing Address:								
City:				Zip:				
Phone:			Ext.			FAX:		
E-Mail Address:								

**AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION**

The undersigned hereby affirms that the statements contained in the Agreement Funding Application (AFA) are true and complete to the best of the applicant's knowledge.

I certify that this Maternal, Child and Adolescent Health (MCAH) related program will comply with all applicable provisions of Article 1, Chapter 1, Part 2, Division 106 of the Health and Safety code (commencing with section 123225), Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 142), and any applicable rules or regulations promulgated by CDPH pursuant to this article and these Chapters. I further certify that this MCAH related program will comply with the MCAH Policies and Procedures Manual, including but not limited to, Administration, Federal Financial Participation (FFP) Section. I further certify that this MCAH related program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Service Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. section 701 et seq.). I further agree that this MCAH related program may be subject to all sanctions or other remedies applicable if this MCAH related program violates any of the above laws, regulations and policies with which it has certified it will comply.

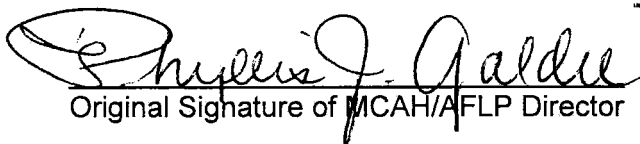


Original Signature of Official authorized to
commit the Agency to an MCAH Agreement

DIRECTOR, HEALTH SERVICES
Title

NEDA WEST
Name (Type or Print)

8-10-10
Date



Original Signature of MCAH/AFLP Director

SUPERVISING PUBLIC HEALTH NURSE
Title

PHYLLIS J GOLDIE
Name (Type or Print)

7-26-10
Date