



**CARES PLUS PROGRAM ROUND 2
LOCAL CASH MATCH PARTNERS**

| | |
|-------------------|--|
| Lead Agency Name: | |
| County Name: | |

1. List all local cash match funding partners and their cash contribution

I affirm that my agency is a funding partner with the local First 5 Commission in the Cares Plus Program Round 2 from July 1, 2013 - June 30, 2016. I understand the program, administrative, audit and statewide evaluation requirements.

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|-------------------------------------|--------|--------|--|--------------|--|
| Organization Name: | | | | | |
| Address: | | | | | |
| City: | | State: | | Zip Code: | |
| Name (print): | | | | | |
| Signature: | | | | | |
| Title of Authorized Representative: | | | | | |
| E-mail and phone contact: | | | | | |
| Describe Local Cash Match : | Annual | | | 3 year total | |

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|-------------------------------------|--------|--------|--|--------------|--|
| Organization Name: | | | | | |
| Address: | | | | | |
| City: | | State: | | Zip Code: | |
| Name (print): | | | | | |
| Signature: | | | | | |
| Title of Authorized Representative: | | | | | |
| E-mail and phone contact: | | | | | |
| Describe Local Cash Match: | Annual | | | 3 year total | |

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|--------------------|--|--------|--|-----------|--|
| Organization Name: | | | | | |
| Address: | | | | | |
| City: | | State: | | Zip Code: | |



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|-------------------------------------|--|
| Name (print): | |
| Signature: | |
| Title of Authorized Representative: | |
| E-mail and phone contact: | |
| Describe Local Cash Match: | Annual 3 year total |

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|-------------------------------------|--|--------|--|-----------|--|
| Organization Name: | | | | | |
| Address: | | | | | |
| City: | | State: | | Zip Code: | |
| Name (print): | | | | | |
| Signature: | | | | | |
| Title of Authorized Representative: | | | | | |
| E-mail and phone contact: | | | | | |
| Describe Local Cash Match: | Annual 3 year total | | | | |

Duplicate chart as needed for additional partners.