OMB Number: 4040-0004
Expiration Date: 12/31/2019

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 08/15/2018

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Florida Department of Health

* b. Employer/Taxpayer Identification Number (EIN/TIN): 59-3502843

* c. Organizational DUNS: 3642150610000

d. Address:

* Street1: 4052 Bald Cypress Way
Street2: Bin A08
* City: Tallahassee
County/Parish: Leon
* State: FL: Florida
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 32399-1710

e. Organizational Unit:

Department Name: Florida Department of Health

Division Name: DCHP-Disease Control and Healt

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: W. David
Middle Name:
* Last Name: Polk
Suffix:

Title: Environmental Specialist III

Organizational Affiliation:
Division of Disease Control and Health Protection

* Telephone Number: 850-901-6510
Fax Number: 850-487-0684

* Email: david.polk@flhealth.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Environmental Protection Agency

11. Catalog of Federal Domestic Assistance Number:

66.472

CFDA Title:

Beach Monitoring and Notification Program Implementation Grants

*** 12. Funding Opportunity Number:**

EPA-CEP-01

* Title:

EPA Mandatory Grant Programs

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

1238-Coastal counties of the State of Flori

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Coastal Beach Water quality monitoring and Notification program.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant FL-002 * b. Program/Project attach

Attach an additional list of Program/Project Congressional Districts if needed.

1244-SF424-attachment I.pdf [Add Attachment] [Delete Attachment] [View Attachment]

17. Proposed Project:

* a. Start Date: 08/01/2018 * b. End Date: 07/31/2019

18. Estimated Funding ($):

* a. Federal	432,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	432,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on ____.

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

[Add Attachment] [Delete Attachment] [View Attachment]

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: Carina

Middle Name:

* Last Name: Blackmore

Suffix: DVM, PhD,

* Title: Director, Division of Disease Control and Hea

* Telephone Number: 850-245-4411 Fax Number:

* Email: carina.blackmore@FLhealth.gov

* Signature of Authorized Representative: W. David Polk * Date Signed: 08/15/2018