

**MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES**  
**REQUEST FOR PROPOSAL COVER SHEET**

Title: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please specify which RFP you are responding to)

Submitted by:

1. Name of Organization \_\_\_\_\_  
\_\_\_\_\_

2. Address \_\_\_\_\_  
\_\_\_\_\_

3. Phone \_\_\_\_\_

4. Fax # \_\_\_\_\_

5. Email \_\_\_\_\_  
\_\_\_\_\_

6. Name of Contact Person \_\_\_\_\_

Title \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Agency Authorization Signature)  
(Date)