

**NEW YORK STATE OFFICE FOR THE AGING
CONTACT INFORMATION FORM
Grants of \$10,000 or Less**

* Vendor Number: _____

Program Period: From: _____ To: _____

Organization: _____
(as shown on Certificate of Incorporation)

Address: _____
(please provide the address of office responsible for grant administration)

Program Name: _____

Program Address: _____

1) Contact Person for official correspondence (e.g., Executive Director, CEO):

Name: _____ Title: _____

Address: _____

Phone: () _____ Email: _____

2) Primary Contact Person for Program Questions:

Name: _____ Title: _____

Address: _____

Phone: () _____ Email: _____

4) Contact Person for Contracting/Fiscal Questions:

Name: _____ Title: _____

Address: _____

Phone: () _____ Email: _____

* If your organization is not currently registered with the New York State Vendor File administered by the Office of the State Comptroller (OSC), please visit:

https://www.osc.state.ny.us/vendor_management/forms.htm for information and assistance.