

DEPARTMENT OF HEALTH AND HUMAN SERVICES ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to 84.5(a) of the regulation {45 C.F.R. 84.5 (a)}, the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments or other assistance made after such date on application for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representation and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in §84.5(b) of the regulation {45 C.F.R. 84.5(b)}.

The recipient: {Check (a) or (b)}

- a. ☐ employs fewer than fifteen persons;
- b. ☐ employs fifteen or more persons and, pursuant to §84.7(a) of the regulation [45 C.F.R. 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with the Health and Human Services regulations: _____

Name of Designee (Type or Print)

_____ Name of Recipient (Type or Print)	_____ Street Address or P.O. Box
_____ (IRS) Employer Identification Number	_____ (IRS) Employer Identification Number City
_____ Area Code - Telephone Number	_____ State Zip

I certify that the above information is complete and correct to the best of my knowledge.

Date

Signature and Title of Authorized Official