

SIGNATURE PAGE

CC-14-2025

To the Monmouth County Board of County Commissioners:

**THE UNDERSIGNED HEREBY DECLARES THAT
I (WE) HAVE CAREFULLY EXAMINED THE SPECIFICATIONS.
I (WE) HEREBY CERTIFY PRICES QUOTED ARE IN ACCORDANCE
WITH YOUR REQUIREMENTS.**

Company Name: New Hope Integrated Behavioral Health Care
(PRINT)

Preparer's Name: David Roden, LCSW, LCADC, President & COO
(PRINT)

Signature:  December 8, 2025
(DATE)


Address: 80 Conover Road
Marlboro, NJ 07746


Telephone No.: 732-946-3030

Fax No.: 732-946-4891

E-Mail Address: drodan@newhopeibhc.org
***** (This should be the email where Contracts would be sent) *****

Contact Person: David Roden, LCSW, LCADC, President & COO

FEIN: 
(Federal Employee ID)

BRC: 
(Business Registration Certificate)

(Revised 2/2017)

APPLICATION FOR FUNDS

HALFWAY HOUSE ASAM LEVEL 3.1 BEDS

| | | | | |
|---|-------------------------------------|----------|--------------------|------------------------|
| 1. Name of Applicant | | | | |
| New Hope Integrated Behavioral Health Care | | | | |
| 2. Street Address | City | County | State | Zip Code |
| 80 Conover Road | Marlboro | Monmouth | NJ | 07746 |
| 3. Name and Title of Fiscal Contact | | | Telephone No. | |
| Marge Ruckaevsky, Vice President & CFO | | | 732-946-3030 x2253 | |
| 4. Name and Title of Director | | | Telephone No. | |
| David Roden, LCSW, LCADC, President & COO | | | 732-946-3030 x2251 | |
| 5. Name and Title of Program Manager | | | Telephone No. | |
| Kristina Bloodgood, MSW, LCADC, Senior Director | | | 732-946-3030 x2413 | |
| 6. Employer ID No. | NJ State License No., if Applicable | | Accreditations | |
| ██████████ | ██████████ (current license #) | | CARF | |
| 7. Location of Proposed Project | City | County | State | Zip Code |
| 190 Chelsea Ave | Long Branch | Monmouth | NJ | 07740 Current location |
| 117 Third Ave | Long Branch | Monmouth | NJ | 07740 New location |
| 8. Type of Agency (check one) | | | | |
| <input checked="" type="checkbox"/> PRIVATE NON-PROFIT <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Other (specify) | | | | |
| COST OF PROJECT | | | | |
| 9. Total Funds Requested Total funds requested: \$1,500,000 ----- Total cost of project \$12,000,000 | | | | |

Certification: The undersigned assures, declares and certifies that to the best of his/her knowledge and belief, all information contained in this application and attachments are true and correct, the application has been duly authorized by the governing body of the Applicant and the services described herein will be provided to the extent agreed upon in the contract developed as a result of this application. The undersigned further understands and agrees that any grant received as a result of this application shall be subject to the conditions and other policies, regulations and rules issued by the County of Monmouth for the administration of grants which include provisions described in the grant application. In addition, the undersigned gives permission to the Division of Behavioral Health to contact State, County and Federal agencies as well as charitable funding sources to discuss and share relevant financial, budget, programmatic and contract information. The undersigned also agrees to make available to the Division upon request, the organization's budget and fiscal audit.

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|--|--|---------------------|
| NAME AND TITLE OF APPLICANT (Print) | SIGNATURE OF APPLICANT | DATE OF APPLICATION |
| New Hope Integrated Behavioral Health Care |  | December 8, 2025 |