

**SIGNATURE PAGE**

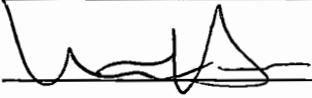
**CC-9-2025**

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: Quantum WellCare LLP  
(PRINT)

Preparer's Name: Maurice Hinson  
(PRINT)

Signature:  06/01/2025  
(DATE)


Address: 1835 Rt 130, 2nd Floor  
North Brunswick, NJ 08902


Telephone No.: 267-634-7011

Fax No.: \_\_\_\_\_

E-Mail Address: M.Hinson@QWC.com  
**\*\*\* (This should be the email where Contracts would be sent) \*\*\***

Contact Person: Maurice Hinson, MD, Chief Executive Officer

FEIN:   
(Federal Employee ID)

BRC:   
(Business Registration Certificate)

(Revised 2/2017)

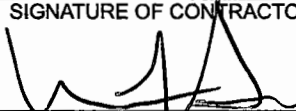
**APPLICATION FOR FUNDS**

~~[Treatment Program]~~

Survey

|   |                                     |  |                            |
|---|-------------------------------------|--|----------------------------|
| 1. Name of Contractor<br><b>Quantum WellCare LLP</b>  |                                     |  |                            |
| 2. Street Address<br><b>1835 Rt 130, 2nd Floor, North Brunswick, NJ 08902</b>   |                                     | City<br><b>North Brunswick</b>   | County<br><b>Middlesex</b> |
| 3. Name and Title of Fiscal Contact<br><b>Maurice Hinson, MD, CEO</b>   |                                     | Telephone No.<br><b>267-634-7011</b>   |                            |
| 4. Name and Title of Director<br><b>Maurice Hinson, MD, CEO</b>   |                                     | Telephone No.<br><b>267-634-7011</b>   |                            |
| 5. Name and Title of Program Manager  |                                     | Telephone No.  |                            |
| 6. Employer ID No.  | NJ State License No., if Applicable | Accreditations<br><b>MD</b>  |                            |
| 7. Location of Proposed Project<br><b>Monmouth County Hall of Records, 1 E. Main St, Freehold, NJ 07728</b>   |                                     | City<br><b>Freehold</b>  | County<br><b>Monmouth</b>  |
| 8. Total Proposed Level of Service in 2023/2024   |                                     | 9. Unit of Service Cost in 2023/2024   |                            |
| 10. Type of Agency (check one)<br><input type="checkbox"/> PRIVATE NON-PROFIT <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Other (specify) <b>private for profit</b> |                                     |  |                            |
| 11. If political subdivision, covered by NJ Civil Service Merit System?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A   |                                     | 12. Affirmative Action Plan<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                            |
| 13. If grant is awarded, will funds be used to replace other funds which would be available in absence of award?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                     |  |                            |
| <b>COST OF PROJECT</b>  |                                     | <b>\$100,000</b>   |                            |
| 14. Total Funds Requested   |                                     |  |                            |

**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 Contractor 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.

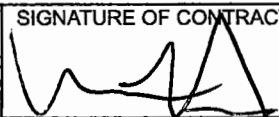
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|--|--|--|
| NAME AND TITLE OF CONTRACTOR (Print)<br><b>Maurice Hinson, MD, CEO</b> | SIGNATURE OF CONTRACTOR<br> | DATE OF APPLICATION<br><b>06/01/2025</b> |
|--|--|--|

**APPLICATION FOR FUNDS**

**[Treatment Program]**

|   |  |                                      |   |
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| 3. Name and Title of Fiscal Contact<br><b>Maurice Hinson, MD, CEO</b>   |  | Telephone No.<br><b>267-634-7011</b> |   |
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|--|--|--|