COVID-19 RESPONSE FUND APPLICATION

LIVE UNITED®

Contact Name: ________________

Contact Title: ________________

Email: ________________________

Phone: (____) _____-_________

Organization Name____ **Website**________________________________

Organization Address____ **City, State Zip** ___________________________

Is your organization a non-profit corporation designated by the IRS as 501(c)(3) or other nonprofit designation?
Yes _____ **No** _____ (If no, is there a fiscal agency to meet this requirement? _______) **EIN #** ____________________

Is this request for a(n) ☐ immediate/emergency need ☐ intermediate/ongoing need ☐ long-term/recovery need

Does this request serve Fountain or Warren County? ☐ Yes ☐ No **Amount Requested:** _________________

Select the category below that will be supported (Select as many as applicable)**:**

☐ Housing Assistance ☐ Utility Assistance ☐ Childcare ☐ Prescriptions ☐ Mental Health/Substance Use

☐ Food ☐ Non-profit Sustainability ☐ Community Development Initiative ☐ Others not listed: ______________

Please choose one of the following options:
Option 1: Please provide a description of how technology, which is not currently being utilized could support continuation of program services to constituents. Be sure to mention any measurable outcomes to demonstrate impact of the funds. Additional clarification may be required.

Option 2: Please describe what specific financial assistance will be provided through these funds and how it aligns with services already provided by the organization. Be sure to mention if any duplication of services exists, measurable outcomes to demonstrate impact of the funds, collaborations if any and demonstrated financial need. Additional clarification may be required.

Option 3: Please describe in detail the request for support in sustainability of operations. Be sure to mention if any duplication of services exists, measurable outcomes to demonstrate impact of the funds, collaborations if any and demonstrated financial need. Additional clarification may be required. (Attach a separate sheet if necessary)

Option 4: Please provide in detail the request for a community development initiative to support during or after the current public health crisis. Be sure to mention if any duplication of services exists, measurable outcomes to demonstrate impact of the funds, collaborations if any and demonstrated financial need. Additional clarification may be required. (Attach a separate sheet if necessary)

Executive Director Name **Executive Director Signature** **Date**