APPLICATION FOR ORGANIZATION / AGENCY

1. Name of Organization/Agency: _____ Federal ID #: _____

   Street Address/Post Office Box: _____

   City/Town: _____ State: _____ Zip Code: _____

   Email Address: _____ Phone: _____ Alt Phone: _____

   Contact Person Name: _____ Title: _____

2. Have you previously received funds from UCEMCCares, Inc.? ☐Yes ☐No
   If yes, please list and include receipts/invoices of those expenditures:

Date	Amount	Date	Amount

3. Is your organization/agency exempt from payment of income tax: ☐Yes ☐No
   If yes, a copy of form 501(c)(3) from Internal Revenue Service AND either a Form 990 or a Financial Statement must be attached.

4. Primary funding agency of applicant. List source(s) from which you already receive revenue.

   _____ _____
   _____ _____
   _____ _____

5. Is your organization/agency currently located in the UCEMC service area? ☐Yes ☐No

6. Do members of this organization contribute to UCEMCCares Inc. by agreeing to have their UCEMC bills rounded up to the nearest dollar? ☐Yes ☐No

7. State purpose of request. List specifically how funding will be utilized. (Attach additional sheets if necessary.)

   _____

   _____

8. Estimated total amount needed for project: $ _____
   Totals from other funding sources: $ _____
   Total requested from UCEMCCares, Inc: $ _____

9. Which county(ies) in the UCEMC service area do you serve and what is the total number of residents served in each county?

- ☐ Smith County _____
- ☐ Putnam County*** _____
- ☐ Overton County _____
- ☐ Jackson County _____

***Please indicate number excluding city residents

10. Please share any other information you feel is important for the reviewers to know about your project.

_____

_____

_____

11. Please list three references from outside your organization that have knowledge of your programs and this request. (Must not be a relative of applicant, member of the UCEMCCares, Inc. Board, member of the UCEMC Board of Directors or employee of UCEMC.)

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

12. Please list three references employed within your organization and/or managing your organization that have knowledge of your program and this request. (UCEMCCares, Inc. reserves the right to request verification of the applicant's agency status or authority to act on behalf the organization).

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

The information contained in this statement is for the purpose of obtaining funding from UCEMC Cares, Inc. on behalf of the undersigned. Each undersigned understands that the information provided herein is used in deciding to grant funding, and each undersigned represents and warrants that the information provided is true and complete and the UCEMCCares, Inc. Board of Directors may consider this statement as continuing to be true and correct until a written notice of change is provided. The UCEMCCares, Inc. Board of Directors is authorized to make all inquiries they deem necessary to verify the accuracy of the statements made herein. In addition, applicant agrees to the sharing of information provided herein with other organizations/agencies by UCEMCCares, Inc. Board of Directors.

Name of Organization/Agency _____ Date _____

Signature of Representative _____ Title of Representative _____

UCEMCCares, Inc. *offers its programs to all eligible persons regardless of race, color, national origin, age or disability, and no one shall be excluded from participation in, admission or access to, denied the benefits of, or otherwise be subjected to discrimination under any of this organization's programs or activities.*

Submit Application to:
UCEMCCares, Inc.
PO Box 159
Carthage, TN 37030

For Office Use Only: Approved Yes ☐ No ☐ Amount Paid: _____

Category: _____ Date Paid: _____