

COVID-19 RESPONSE FUND APPLICATION

LIVE UNITED®

Organization Name _____ Website _____

Organization Address _____ City, State Zip _____

Contact Name: _____ Email: _____ Phone: (____) ____-_____

Is your organization incorporated as a non-profit corporation and designated by the IRS as 501(c)(3) organization?
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 Carroll 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. (Attach a separate sheet if necessary)

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

