GRANT APPLICATION

PLEASE COMPLETE AND RETURN WITH REQUIRED DOCUMENTATION AND INFORMATION REQUIRED UNDER THE DISTRICT'S GRANT POLICY, PROCEDURES AND GUIDELINES

Provide the following information for the grant applicant and for all partnering and/or subcontracting entities, if any. Use a separate attachment or page for each item below, as necessary, to fully describe information required. Please indicate "See Attachment" where appropriate.

Applicant:

_____

Subject of Request:

_____

Intended Use of Funds in Detail:

_____

_____

Describe how intended use of funds will further delivery of health services within the District:

_____

_____

Amount Requested $_____ Grant Period: _____

Address:

_____

_____

(City) (State) (Zip)

Individual Accountable For Funds:

Name: _____ Title: _____

Telephone: _____ Facsimile: _____

E-Mail: _____

Years in business: _____ Number of employees: _____

Business Licenses, Certifications or Registrations #:

_____

By signing below, the undersigned hereby certifies under penalty of perjury that: (1) the information contained within this this application is true and correct to the best of my personal knowledge, information and reasonable belief; (2) the grant applicant has read and is familiar with all of the District's grant policies, procedures and guidelines; (3) the grant applicant hereby waives each and all claims and right(s), if any exist, to in any form appeal or otherwise legally challenge each and all decisions of the Kingsburg Tri-County Health Care District pertaining to this grant application; and (4) the governing body of the grant applicant has duly authorized me to sign this grant application.

Printed Name: _____ _____ _____

Signed (Date) Total pages attached