SOUTHWEST MEMBERS CARE INC.

Change for Community Change

www.stemc.com/southwest-members-care-inc

P.O. Box 959
Brownsville, TN 38012
731-772-1322

Application for Grant

1. Name of Organization: _____

2. Southwest TN EMC Account #: (12 digits) _____

3. Location: _____

4. **Complete Mailing Address:**

   _____
   Street/PO Box

   _____
   City State Zip Code

5. Contact Person _____
   Please Print Legibly Name Title Area Code & Phone number

6. Has this organization received a Southwest Members Care Grant in the last 12 months?
   ◯ Yes ◯ No

If yes, list dates and amounts of grants received. _____

_____

7. Do members of this organization contribute to Southwest Members Care by agreeing to have their Southwest TN EMC bills rounded up to the nearest dollar?
   ◯ Yes ◯ No

8. Organization's Federal Tax ID Number: _____ _____ - _____

9. Is this organization a 501 (c) 3?

◯ Yes ◯ No

If yes, a copy of your 501 (c) 3 determination letter from the Internal Revenue Service must be attached.

10. Primary Funding Agency of Organization:

_____

11. Please indicate which Southwest TN EMC counties that this organization serves:

◯ Chester
◯ Madison
◯ Haywood
◯ Tipton
◯ Henderson
◯ Hardeman
◯ Lauderdale
◯ Fayette
◯ Shelby
◯ Crockett
◯ McNairy

12. Does this organization provide services outside Southwest TN EMC service area?

◯ Yes ◯ No

If yes, please provide information on number served and location. _____

_____

13. If the program requesting funds serves students in the schools, please list the schools served:

_____

_____

_____

14. Purpose of Request: (Include amount requested and specifics of how funds will be used.)
**Please attach a detailed quote for items to be purchased. **

_____

_____

_____

_____

_____

_____

15. Estimated Total amount needed for project. $ _____

    Totals from other funding sources (list sources and amounts):

    _____ $ _____

    _____ $ _____

    _____ $ _____

    _____ $ _____

    TOTAL requested from Southwest Members Care: $ _____

16. How is this program measured for effectiveness (i.e. records kept on number of families served, monetary benefits to families or community, lives changed, etc.)?

    _____

    _____

    _____

17. Please list three references from outside your organization who have knowledge of your programs and this request.

    1. Reference: _____

    Please Print Legibly Name Area Code & Phone number

    _____

    Employer Title

    _____

    Street/PO Box

    _____

    City State Zip Code

2. Reference: _____

Please Print Legibly Name Area Code & Phone number

_____

Employer Title

_____

Street/PO Box

_____

City State Zip Code

3. Reference: _____

Please Print Legibly Name Area Code & Phone number

_____

Employer Title

_____

Street/PO Box

_____

City State Zip Code

The information contained in this statement is for the purpose of obtaining funding from Southwest Members Care 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 Southwest Members Care Board of Directors may consider this statement as continuing to be true and correct until a written notice of change is provided. The Southwest Members Care Board of Directors is authorized to make all inquiries they deem necessary to verify the accuracy of the statements made herein. I/we understand that grant funds awarded are subject to annual audits and agree, if audited, to submit documentation that any awarded funds were expended as specified in this application.

_____

NAME OF ORGANIZATION

_____

SIGNATURE OF REPRESENTATIVE

_____

TITLE

_____

DATE