



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.)

****Application will NOT BE CONSIDERED without a detailed quote from the vendor for the items/services 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