COLLABORATIVE

45-149 Smurr Street Suite A Indio, CA 92201 or PO box 855 Indio, CA 92201

REFERRAL FOR YOUTH FINANCIAL SUPPORT PROGRAM

Applicant(s) Please check one: _____ **Individual** _____ **Agency**

Individual or Organization Name:

EIN/Non-Profit #:(if applicable)

Are you a member of CVCT: ___ Yes ___ No

Contact Person:

Address:

Phone #:

E-mail:

Amount Requested: $

Your Funding Deadline:

Purpose/Objective: (Be sure to include answers to the following: *****What will the requested funding be used for? *****How will this funding benefit at-risk/low income youth in the East Coachella Valley? *****If this is an agency request, how many youth will be served from this funding? Please provide Demographic information of target population to be served (your geographic area, ethnicity percentage, and if recipient(s) family income is at or below Federal Poverty Guideline). *Attach 1 additional page if needed.*)

_____

_____

_____

_____

_____

_____

Will you be able to provide a short report or presentation to CVCT on your outcome? Yes No

Budget for Use of Funds: (All Applicants ***must*** complete this section.)

Name of item or service requested (ex. Program fees, supplies, counseling, etc.)	Amount requested (ex. $375.00)	Cost breakdown (ex. $12.50 x 30 students)

Signature:

Date:

Who do we make the Check payable to?

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CVCT Board of Directors Action: ____ Declined _____ Approved

Approval Date/Amount:

Date Applicant Notified:

Check Number:

(Rev. 6/1/2020)