Ultrasound Program

Application

GENERAL INFORMATION

Please indicate which matching funds program option being applied for:

_____ Ultrasound Machine Funding

_____ Ultrasound Machine and Vehicle Funding for Mobile Unit

Sponsoring state/provincial or local council: _____ Number: _____

Council location: _____ State/Province _____ The council voted to approve proceeding with fundraising for this program on (date): _____

Contact Person: _____ Title: _____ Date: _____

Telephone #: _____ Address: _____

Pregnancy Center: _____ Telephone: _____

Contact Person: _____ Title: _____ Email: _____

Address: _____ City/Town: _____ State/Province: _____ Zip Code: _____

U.S. – Tax Status: ____ 501(c)(3) ____ Other: _____ PCC's U.S. Tax ID # (EIN): _____

Canada – The Canadian Revenue Agency (CRA) has approved this PCC as a registered charity authorized to perform limited medical services: (circle) Yes No Canadian Registered Charity #:_____

National Affiliations: (circle) NIFLA Care Net Heartbeat other: _____

(_____) This pregnancy center has no policies that are anti-Catholic in any way and does not engage in practices that would tend to lead Catholic women away from their faith.

(_____) This pregnancy center does not advocate or refer for birth control.

Does the pregnancy center require (_____) employees, (_____) volunteers or (_____) patients/clients to sign a Statement of Faith?

Yes ____ (If yes, please enclose a copy.) No _____

ULTRASOUND MACHINE FUNDING

Please verify each of the following statements and indicate with a checkmark:

_____ The center complies with all state/provincial/local laws/regulations to operate an ultrasound machine.

_____ The pregnancy center's medical director is: Dr. _____

Address: _____

_____ The machine will be staffed with trained, licensed, and experienced medical personnel.

_____ The pregnancy center will offer limited diagnostic medical services, not non-diagnostic/entertainment services.

_____ The center has adequate insurance for operation of the ultrasound machine.

Ultrasound Machine Manufacturer: _____ Model: _____

Type of ultrasound machine to be purchased: 2D ____ 3D ____ 4D ____ other _____

List price: $_____ Check: ____ new ____ refurbished ____ portable

Machine's actual cost (not including freight, taxes, training, salaries, etc.): $_____

Please list the council number of any other councils which assisted in or contributed to the state council's/ council's fundraising efforts. # _____ # _____ # _____ # _____

Briefly describe anything particularly noteworthy about the pregnancy center (near abortion clinic, colleges, military base, etc.) and the major fund raising programs used by your council (use additional paper if needed):

_____

_____

_____

_____

_____

Total amount raised to date by the council (must be at least 50% of the machine's actual cost): $ _____

VEHICLE FUNDING FOR MOBILE UNIT

(If not applicable, skip to next section)

Vehicle type: (circle one) Bus RV Truck Van other: _____

Vehicle Manufacturer: _____ Model/Year: _____

(circle one) Purchased: New Used Leased Donated other: _____

Obtained from: (circle one) Manufacturer/Dealership ICU Mobile Save the Storks

Private Seller other: _____

Original list price of vehicle/mobile unit: $_____

Actual purchase price (after discount, if any) of vehicle (not including registration, fees, taxes, driver costs, maintenance, fuel, etc.): $_____

Does vehicle come fully equipped to offer ultrasound services? (Circle) Yes No

If no, describe conversion work done/to be done: _____

_____

Total estimated/actual costs to convert vehicle to mobile medical unit: $ _____

Total mobile unit costs (vehicle + conversion expenses, if any): $ _____

Has the council completed fundraising to cover the full cost of purchase/purchase and conversion of the vehicle/mobile unit? (Circle) Yes No

If yes, what is the total amount of funds raised by the council? *(Council funds raised + expected Supreme Council grant, must equal or exceed the total cost of purchase/purchase and conversion expenses for the mobile unit, including the cost of the ultrasound machine)* $ _____

Please verify each of the following statements and indicate with a checkmark:

_____ The mobile unit complies with all state/provincial/local laws/regulations regarding registration/operation of a mobile medical unit. The vehicle will park on private property and/or fit in intended public parking spaces in compliance with local zoning and parking laws and permitting processes.

_____ If required, the pregnancy center will seek certification of the mobile unit by health/housing authority inspection.

_____ The mobile unit will be driven by licensed, experienced, insured drivers.

_____ The mobile unit has adequate motor vehicle insurance.

Briefly describe anything particularly noteworthy about the mobile unit, including how/where it will be used (use additional paper if needed): _____

_____

GRANT AMOUNTS

A. Ultrasound Machine (50% of the actual cost of the machine): $ _____

B. Mobile unit (if applicable):
(The lesser of: the purchase price of the vehicle, plus conversion expenses (if any), or, 50% of the actual cost of the machine): $ _____

Total grant amount (Lines A + B) requested from Supreme Council Office: $ _____

Please make the Supreme Council's check for matching funds payable to: ___ the pregnancy center listed above; or,
___ (State Council Charity) _____ EIN/Charity #_____
Please mail check to (name/address): _____
_____

State Deputy's signature: _____ Date: _____

Enclosures:

1. Ultrasound Machine Price Quote

2. Vehicle Price Quote (if applicable)

3. Documentation for estimated/actual costs of conversion expenses (if any)

Email a copy of this document to: fraternalmission@kofc.org

(Councils should also retain a copy of this completed form for their files)