

THE HOWARD FUND

ORGANIZATION Application for Assistance

Date of Application _____

CONFIDENTIAL

Medical procedures are not considered by the Howard Fund.

Instructions:

1. Print application.
2. Fully complete all parts of the application, even if N/A (not applicable). Sign and date the application.
3. You may mail your application to : Division of Vocational Rehabilitation, c/o Joyce Tucker, 1575 Sherman St., 4th Floor, Denver, Colorado 80203; give the application to any member of the Board.

AGENCY INFORMATION:

Name	Social Security #/Tax ID #	Telephone #
Address	Apt./Space #	City/State/Zip

REFERRAL SOURCE:

FINANCIAL NEEDS/AMOUNT REQUESTED: \$

Grantee Process and Responsibilities: All proposals must be made in writing. Only one copy needs to be submitted. Submit the proposal to any member of the Board, or you may mail it to the Chairperson at the above address. Proposals must contain defined plans for using the funds including to whatever extent possible the measurable benefit(s) expected from the usage of these funds. If funds are for programs or provision of services the proposal must include:

- A definition of the purpose, target population, expected outcomes and how success will be evaluated.
- When applicable, evidence that other sources of funds are available to begin and contribute to the success of demonstration and innovation projects.
- A plan for developing funds which will support an ongoing program and the target dates for obtaining such funds.
- The Board will request that the successful grantee provide periodic reports and information to evaluate the effectiveness and/or outcome of services.

Failure to comply to the grant provisions may disqualify grantees from the continuation of funds or the future receipt of other funding

Fund will be used for (please be specific – who benefits, etc.): - attach sheet if necessary.
Please identify if demonstrative or innovative.

This is a _____ one-time request OR _____ monthly (for _____ -months-cannot exceed 12)

OTHER SOURCES CONTACTED FOR ASSISTANCE:

Organization	Amount Requested	Amount Pledged	Date

I/we certify that this request will serve only individuals who are legally blind.
I/we understand that failure to comply with the requirements of the Howard Fund Guidelines may result in disqualification and termination of future installment payments.
I/we hereby certify that all information contained on this application is true and correct.

Printed Name

Signature and Date

DO NOT WRITE BELOW THIS LINE

Request #	Date Presented	Decision

The Howard Fund is administered by the Colorado Department of Human Services through the Division of Vocational Rehabilitation.

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