Ultrasound Initiative

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 initiative on (date): _____

Contact Person: _____ Title: _____ Date: _____

Telephone #: _____ Address: _____ Email: _____

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: Yes ☐ No ☐ Canadian Registered Charity #: _____

National Affiliations: 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: Bus ☐ RV ☐ Truck ☐ Van ☐ other: _____

Vehicle Manufacturer: _____ Model/Year: _____

Purchased: New ☐ Used ☐ Leased ☐ Donated ☐ other: _____

Obtained from: 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? 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? 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)