

**McLean Electric Trust, Inc.**

**PO Box 399**

**Garrison, ND 58540**

**Attn: Sonja Moe**

**701-463-6700**

**1-800-263-4922**

**www.mcleanelectric.com**



**Application for Donation**

**Name of Organization:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

1. Please include your 501(c)(3) letter from the IRS to qualify for this grant. **To obtain a letter contact the IRS at 877-829-5500. If no, your organization does not qualify for a grant from the McLean Electric Trust.**

2. A copy of the organizations **most recent year financial statement(s)** must be provided.

3. Number of Individuals, families or groups served outside McLean Electric Cooperative's service area in the last year: \_\_\_\_\_

4. Does the organization serve within McLean Electric Cooperative's service area? Yes \_\_\_\_\_ No \_\_\_\_\_  
**(If yes please provide information on number served and location.**

5. Amount requested: *(Maximum \$2,500.00 per year, per organization)* \$ \_\_\_\_\_

6. State the Purpose of the request: **include specifics of how funds will be used.** (Use a separate page if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Incomplete applications will be denied)**

**If the Grant is for an Organization or Agency please answer the following:**

List all other sources of funding and the proposed budget for this project or request.  
(Use a separate page if needed)

1. Add a detailed quote or estimate for this project or request.  
(Use a separate page if needed)
  
2. Please list three references (name, address, home phone number and work phone number)
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_

**If the Grant is for an Individual please Answer the following:**

**Medical Assistance Information:**

Recipients Name: \_\_\_\_\_

Recipient Address: \_\_\_\_\_

1. Is the recipient a member of McLean Electric Cooperative? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Does the Recipient have health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Has the recipient applied for charity care, Hill Burton, Medicaid or other program through the health provider? Yes \_\_\_\_\_ No \_\_\_\_\_ Accepted \_\_\_\_\_ Declined \_\_\_\_\_ Not Available \_\_\_\_\_
4. Is the recipient able to work? Yes \_\_\_\_\_ No \_\_\_\_\_
5. How has the spouse's job or ability to work been affected? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Important! Please Read and Sign.**

The information contained in this statement is for the purpose of obtaining funding from the McLean Electric Trust, Inc. 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 that the McLean Electric Trust Inc. may consider this statement as continuing to be true and correct until a written notice of change is provided. The McLean Electric Trust, Inc. is authorized to make all inquiries they deem necessary to verify the accuracy of the statements made herein.

**Do you Have:**

- Signature \_\_\_\_\_
- Financial Statement \_\_\_\_\_
- 501 (c)(3) Letter \_\_\_\_\_
- Estimates \_\_\_\_\_

\_\_\_\_\_  
**Signature of Applicant/Recipient**

\_\_\_\_\_  
Title in Organization or Agency

\_\_\_\_\_  
Date

**(Incomplete applications will be denied)**