APPLICATION FOR ELIGIBILITY

To Receive Federal Surplus Property (41 CFR 101-44.207)

I. LEGAL NAME & MAILING ADDRESS OF APPLICANT ORGANIZATION:

_____
Name of Organization *Federal Tax ID#*

_____
Mailing Address (P.O. Box #, Street, City & State) *Zip Code*

_____
Street Address/Location (if different from mailing address)

_____
County *Telephone #*

II. APPLICANT STATUS (CHECK ONE):

☐ Public Agency including Public Schools (evidence must be provided)
☐ Nonprofit, tax-exempt Organization

III. TYPE OR PURPOSE OF ORGANIZATION:

☐ State	☐ College or University	☐ Child Care Center	☐ Training Center	☐ Medical Institution
☐ County	☐ Secondary School	☐ School for Handicapped	☐ Radio/TV Station	☐ Hospital
☐ City	☐ Elementary School	☐ School for Developmentally Disabled	☐ Library	☐ Health Center
☐ School District	☐ Preschool	☐ Museum	☐ Sheltered Workshop Training Program	☐ Clinic
	☐ Program for Older Individuals	☐ Provider of Assistance to Homeless Individuals	☐ Other (Specify) _____	

IV. PROVIDE A WRITTEN DESCRIPTION OF PROGRAM OR SERVICES OFFERED, INCLUDING A DESCRIPTION OF FACILITIES OPERATED. *(REQUIRED)*

V. SOURCES OF FUNDING (Attach Supporting Documentation):

☐ Tax supported ☐ Grant ☐ Contributions ☐ Other (Specify) _____

VI. HAS THE ORGANIZATION BEEN DETERMINED TO BE TAX EXEMPT UNDER SECTION 501 OF THE INTERNAL REVENUE CODE OF 1954: _____ *(COPY REQUIRE)*

VII. HAS THE ORGANIZATION BEEN APPROVED, ACCREDITED, OR LICENSED? _____ *(COPY REQUIRED)* BY WHAT AUTHORITY? _____

VIII. *Date* _____ *Print Name* _____

Title _____ *Signature of Authorized Official* _____

FOR STATE USE ONLY

The applicant has been determined as ☐ *eligible* ☐ *ineligible* ☐ *conditionally eligible* ☐ *a public agency,* ☐ *nonprofit education,* ☐ *nonprofit health*

Eligibility expires _____ Account # _____

_____ _____
Date *Director*