



Request Form

Date:

Name of Client:

Service/Bill

Requested to be Paid:

Organization
Representative

Requesting Funds:

Reason for Request:

Amount Requested:

I attest that the above client is truly indigent and in need of emergency funds and other funding resources are unavailable.

Signature of Initiating Request:

Signature of Supervisor:

PROVIDE DOCUMENTATION TO SHOW HOW FUNDS WILL BE SPENT, ACCOUNTED FOR, AND AUDITED IF NECESSARY.

GRANT FUNDS FOR YOUR CLIENTS WILL BE USED FOR EMERGENCY FINANCIAL NEED TO BE AWARDED NO MORE THAN ONCE YEARLY PER INDIVIDUAL AND NOT TO EXCEED \$500 PER CLIENT APPLICANT.



703.627.7509



sedonaltd.org@gmail.com
projectsedonaltd@gmail.com



sedonaltd.org