

# ULTRASOUND PROGRAM 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 program on (date): \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Address: \_\_\_\_\_

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: (circle) Yes No Canadian Registered Charity #: \_\_\_\_\_

National Affiliations: (circle) 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):

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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: (circle one) Bus RV Truck Van other: \_\_\_\_\_

Vehicle Manufacturer: \_\_\_\_\_ Model/Year: \_\_\_\_\_

(circle one) Purchased: New Used Leased Donated other: \_\_\_\_\_

Obtained from: (circle one) 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? (Circle) 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? (Circle) 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](mailto:fraternalmission@kofc.org)**  
*(Councils should also retain a copy of this completed form for their files)*