

NYS Department of Health
Hunger Prevention and Nutrition Assistance Program
OPERATIONS SUPPORT/CAPITAL EQUIPMENT
2-PAGE COVERSHEET 2021-2022

**One copy of this signed 2- Page Coversheet must be received with 10 copies of your application by Friday, May 21st, 2021, 4:00 pm.
Please mail or hand deliver. Do *NOT* fax.**

Agency Name	Agency Number
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Summary of Requested Funds

Funding Category	Amount of Request	Priority (1st, 2nd 3rd?)
Staff	\$	
Utilities	\$	
Space	\$	
Disposables	\$	
Transportation	\$	
Capital Equipment	\$	

Total Request*	\$	*CANNOT exceed \$14,000
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I verify that all the information provided in the accompanying application is accurate to the best of my knowledge. (Two signatures are required.)

Print Name _____ Signature _____ Date _____
(Contact Person)

Print Name _____ Signature _____ Date _____
(2nd Person: Executive Director or Assistant – MUST be different than Contact Person)

PART A: TELL US ABOUT YOUR PROGRAM

Name of Emergency Food Program:	
Site Address:	
Executive Director:	Year Pantry, Kitchen or Shelter Started:

If your program is not a food bank member, please attach documentation that your program has 501(c)(3) federal tax-exempt status (or its equivalent) or has a 501(c)(3) sponsoring organization. The organization submitting a 501(c)(3) is legally and fiscally responsible for the administration of this grant.

Name of contact person:	
The contact person is responsible for the administration of the grant and for submitting relevant documentation.	
Address:	
Phone:	Email address:

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