

The CARES Act, CRF Fund Reimbursement Request Form

Organization Name: _____

Organization Address: _____

Contact Name: _____

Contact Phone: _____

Contact Email: _____

Expenditure Type

_____ Medical Expense (related to control of the spread of COVID19)

_____ Public Health Expense (purchase of PPE, disinfection of public areas, quarantine expenses)

_____ Payroll Expense (public safety, public health, health care, human services)

_____ Social Distancing Mitigation (vulnerable populations, distance learning, telework capabilities, homeless population)

I, _____ hereby attest that no other funds were available, budgeted or requested to cover the request for expenditures submitted for reimbursement under the CRF Fund.

I am authorized to sign on behalf of the organization and agree to all the terms and conditions of the RFP.

Signature

Date