GENERAL INFORMATION

NYC REFUGEE MEDICAL SCREENING AND IMMUNIZATION PROGRAM APPLICANT PROJECT INFORMATION
INDICATE TYPE OF ORGANIZATION CARRYING OUT THE ACTIVITY:

☐ **PUBLIC AGENCY** ☐ **FAITH BASED NON-PROFIT** ☐ **OTHER NON-PROFIT** ☐ **FOR PROFIT**

APPLICANT NAME:_____

EXECUTIVE DIRECTOR: _____

BUSINESS ADDRESS: _____

CITY_____ STATE _____ ZIP CODE_____

PHONE: (____) _____ FAX :(____) _____

Email Address:
_____

PROJECT ADDRESS (if other than business address):
_____
_

PROGRAM CONTACT: _____

ADDRESS_____
_

CITY_____ STATE _____ ZIP CODE_____

PHONE: (____) _____ FAX : (____)_____

Email Address:
_____

What is your organization's Federal Employer Identification number?_____

Applicant Fiscal Year: (Example: July 1 - June 30)?_____

Please provide the following identifying information regarding the project:

Community District(s) *NYC only*: _____ Federal Congressional District(s): _____

State Assembly District(s): _____ State Senate District(s): _____

What is your organization's **6 digit** State Registered Charitable Organization number?_____
Is your organization current with the NYS Office of the Attorney General Charities registration filing requirements? _____ YES _____ NO
If not, why? _____

COUNTY/ COUNTIES WHERE SERVICES ARE TO BE PROVIDED _____

ACCESSIBILITY DETERMINATION

Is project site: wheelchair accessible? ☐ Yes ☐ No

Does your agency conform with Title III ADA requirements? ☐ Yes ☐ No

If facilities are not accessible to persons with disabilities, please state what physical changes will be made to conform to the Americans with Disabilities Act of 1990 and the regulations promulgated thereunder, and the expected completion date for any such physical changes.

_____
_____
_____
_____
_____
_____

Are materials available in alternative formats for persons with disabilities? (i.e. Braille, Audio Recording etc.)
☐ Yes ☐ No

No further entries on this page.