2004 COMBINED FEDERAL CAMPAIGN

LOCAL UNAFFILIATED & MEMBER AGENCIES - APPLICATION REVIEW FORM

Applying Organization:_____

Federation: _____ Reviewer/Affiliation: _____

☐ **Application Accepted** ☐ **Application Denied** Reason: _____ _____ _____ _____ Signature Date	***LFCC Appeal*** Appeal Received: ☐Yes ☐No ☐ Approved ☐ Denied Reason: _____ _____ _____ Signature Date	***OPM Appeal*** Appeal Received: ☐Yes ☐No ☐ Approved ☐ Denied _____ _____ Signature Date

☐ **CONTAINED A COMPLETED APPLICATION FORM:**

☐ Affirming Original Signatures ☐ All Certifications Checked

☐ **ATTACHMENT A - Description of substantial presence *(must meet all criteria in category)***

☐ *LOCAL*	☐ *ADJACENT*	☐ *STATEWIDE*
☐ Dedicated Address ☐ Dedicated Phone Line ☐ Open 15 Hours or More	***Local Requirements plus :*** ☐ Located Within Adjacent Campaign _____ *Name of Campaign*	***Local Requirements plus:*** ☐ 30% Geographic (30 Counties) ☐ Maps & ☐ Service Records **Or** ☐ 30% Target Eligible Population ☐ # Target Population: _____ ☐ # Affected Population:

☐ **ATTACHMENT B - IRS determination letter - 501(c)(3)**

☐ Official documentation authorizing name change (DBA) *(if applicable)*

☐ **ATTACHMENT C - Description of human/health/welfare benefits**

Must provide: ☐ Detailed Description of Activities	***Should provide*** ☐ Services Provided ☐ Who Benefits and How

☐ **ATTACHMENT D - Copy of audit (Must include June 30, 2002 or more current)** Time Frame: _____

☐ N/A ***(Not required if revenue is less than $100,000)*** **GAAP** ☐ Yes ☐ No

☐ **ATTACHMENT E - IRS form 990 (Must include June 30, 2002 or more current)** Time Frame: _____

☐ Form 990*, includes signature of officer* **Accrual** ☐ Yes ☐ No

☐ Form 990EZ, (Must include 990 page 1, 2 and signature page) **Audit & 990** -Dates Match ☐Yes ☐No

-Figures Match ☐Yes ☐No

☐ **ATTACHMENT F – Administration/Fundraising Expenses**

Add line 14 (management & general) and _____

Line 15 (fundraising) +_____ = _____Total

Enter Line 12 (total revenue) _____

Divide total of lines 14 & 15 by line 12. The result is the percentage overhead: _____%

☐ Justification of expenses *(Not required if overhead is 25.0% or less)*

☐ Formal plan to reduce expenses If over 25.0% review: _____2002 _____ 2001

☐ **VERIFY organization has received no more than 80% of its total support/revenues from government sources.**

Divide Line 1c _____ by Line 12 _____ = _____%

Or Divide (Line 1c _____ - Medicaid: _____ = _____) by Line 12 _____ = _____%

☐ **ATTACHMENT G - Annual Report (Must include June 30, 2002 or more current)** Time Frame: _____

☐ Annual Report **Or** ☐ Equivalent Newsletter	***Must Include:*** ☐ Full Description of Activities/Services ☐ Identify Directors/Governing Body	***Should Include:*** ☐ Terms of Office For Officers ☐ Dates, Times, Places of Mtgs

☐ **ATTACHMENT H - Statement of 25 words or less**

2004 NOTES **Agency name: _____**