

ILLINOIS STATE AGENCY FOR FEDERAL SURPLUS PROPERTY (IL-SASP)

**CMS Bureau of Agency Services – Property Control Division
Federal Surplus Property Program
1924 South 10 ½ Street
Springfield IL 62703 PHONE: (217) 785.6903**

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR ELIGIBILITY FORM

(Please type or print in blue or black ink only)

SECTION I: Provide the full legal name of your organization on the first line of this section. Provide the mailing address of your organization as recognized by the U.S. Postal Service. Include ZIP Code. Provide the street address if different from mailing address, or provide directions if located on a rural route or other remote area. List the county in which the organization is actually located and a business telephone number with area code.

SECTION II: Check the appropriate box which describes your organization. If you are unable to determine which status to check, please contact this office for assistance at (217) 785-6903.

SECTION III: Check the appropriate box or boxes (check all that apply) which indicates the type or purpose of your organization.

SECTION IV: A comprehensive written description of all programs or services provided is required. A description of the operational facilities should also be included. Be sure to include information of staff and staff qualifications, hours of operation, services and programs offered, population or enrollment, fees charged, etc. Include samples of pamphlets, catalogs, brochures or posters. If incorporated, include complete copy of Articles of Incorporation with all filing certificates and amendments, and a copy of your current bylaws.

SECTION V: Check the appropriate box which indicates the organization's sources of funding. Supporting documentation indicating the types and amounts of funding must be submitted with the completed application (copies of current budget and/or tax levy, if applicable, are acceptable).

SECTION VI: All applicants making application as "nonprofit, tax-exempt organizations" must provide a copy of the IRS determination letter indicating tax exemption under Section 501 of the IRS Code of 1954. The name and address of the organization on this IRS letter must match the name and address provided in Section I of this application. If not, include sufficient evidence such as amendments to Articles of Incorporation, or Assumed Name filing certificates to establish an "audit trail" of names showing the legal connection.

SECTION VII: Applicants making application as "nonprofit, tax-exempt organization" are required to submit evidence that the applicant is currently approved, accredited, or licensed. Programs for older individuals must include evidence of funding under the Older Americans Act of 1965; Titles IV or XX of the Social Security Act; Titles VIII or X of the Economic Development Act of 1964; or the Community Services Block Grant Act. Providers of assistance to homeless individuals must include a letter from the mayor, county judge, city or county health offices or comparable authority which certifies that applicant is a "provider of assistance to the homeless". The certification must identify the service or assistance being provided and the number of individuals receiving such assistance.

SECTION VIII: Annotate date and provide an original signature of applicant's Authorized Official (President, Chairman of the Board, County Judge, Mayor, City Manager, Executive Director, Administrator, Fire Chief, or other comparable authorized official). Photo copied, rubber stamped, machine produced, carbon, or other facsimile-type signatures are not acceptable.

NOTE: INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. USE THIS INSTRUCTION SHEET AS YOUR CHECK LIST TO ASSURE ALL REQUIRED INFORMATION AND DOCUMENTATION IS PROVIDED. IF YOU HAVE A QUESTION OR NEED ASSISTANCE CALL (217)785-6903. PLEASE RETAIN A COPY FOR YOUR RECORDS AND SUBMIT THE ORIGINAL TO THE ADDRESS ABOVE.

ILLINOIS STATE AGENCY FOR FEDERAL SURPLUS PROPERTY

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APPLICATION FOR ELIGIBILITY

To Receive Federal Surplus Property (41 CFR 101-44-207)

Federal Surplus Account Number Issued: _____ (To be completed by CMS Office)

I. LEGAL NAME & MAILING ADDRESS OF APPLICANT ORGANIZATION:

Name of Organization _____ Federal Tax ID # _____
Mailing Address (P.O. Box #, Street, City & State) _____ Zip Code _____
Street Address/ Location (if different from mailing address) _____
County _____ () Telephone # _____

II. APPLICANT STATUS (CHECK ONE):

- Public Agency including Public Schools (check one) Nonprofit, tax-exempt organization (Provide Evidence)
 Nonprofit Health -OR- Nonprofit Education

III. TYPE OR PURPOSE OF ORGANIZATION:

- State College or University Child Care Center
 County SBA 8(a) Museum
 City/Village Elementary or Secondary School S.E.A. (Scouts, Red Cross)
 Education Program for Older Individuals Radio/TV Station
 Hospital/Health Library Nursing Home
 Township Hospital Public Health / Clinic
 Road District Americans w/ Disabilities Provider to Needy (Food)
 Public Safety Provider to Homeless (Shelters) Veteran Organizations

IV. PROVIDE A WRITTEN DESCRIPTION OF PROGRAM OR SERVICES OFFERED, INCLUDING A DESCRIPTION OF FACILITIES OPERATED. (REQUIRED)

V. SOURCES OF FUNDING (ATTACH SUPPORTING DOCUMENTATION):

- Tax Supported Grant Contributions Other (Specify) _____

VI. HAS THE ORGANIZATION BEEN DETERMINED TO BE TAX EXEMPT UNDER SECTION 501 OF THE INTERNAL REVENUE CODE OF 1954: _____ (COPY REQUIRED)

VII. HAS THE ORGANIZATION BEEN APPROVED, ACCREDITED, OR LICENSED? _____ (COPY REQUIRED) BY WHAT AUTHORITY? _____

VIII. _____
Date

Applicant Signature

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AUTHORIZED REPRESENTATIVES

I. LEGAL NAME & MAILING ADDRESS OF APPLICANT ORGANIZATION:

FEDERAL TAX ID #: _____ Email: _____

Name of Organization _____ Administrative Head _____

Mailing Address (P.O. Box #, Street, City & State) _____ Zip Code _____

Street Address/Location (If different from mailing address) _____

County _____ () Telephone # _____

Send Correspondence to the Above Named Representative _____ () Fax # _____

II. THE FOLLOWING REPRESENTATIVES ARE DESIGNATED TO:

- A. Represent Donee Organization as its authorized agent; and
B. Acquire Federal surplus property on behalf of the Donee Organization; and
C. Obligate necessary Donee Organization funds for this purpose; and
D. Execute Distribution Documents binding the Donee Organization to the terms, conditions, reservations, and restrictions applying to Property obtained through the agency.

III. _____ NEW DESIGNATIONS (Delete all previous authorizations)
_____ ADDITIONAL DESIGNATIONS ONLY (Add to previous authorizations)

IV. REPRESENTATIVES

Table with 3 columns: Print Name, Title, Signature. Multiple rows for listing representatives.

V. CERTIFICATION

Date _____ Signature of Authorized Official (Applicant) _____
Title _____

LENGTH OF ELIGIBILITY GRANTED BY CMS: _____ YEAR(S) (FOR CMS OFFICE USE ONLY)

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NONDISCRIMINATION ASSURANCE

LEGAL NAME & MAILING ADDRESS OF APPLICANT ORGANIZATION:

Name of Organization

Mailing Address (P.O. Box #, Street, City & State)

Zip Code

Street Address/ Location (If different from mailing address)

County

(Name of Organization)

, the donee,

agrees that the program for or in connection with which any property is donated to the donee will be conducted in compliance with, and the donee will comply with and will require any other person (any legal entity) who through contractual or other arrangements with the donee is authorized to provide services or benefits under said program to comply with all requirements imposed by or pursuant to the regulations of the General Services Administration (41 C.F.R. 101-6.2 and 101-B) issued under the provisions of Title VI of the Civil Rights Act of 1964, as amended, section 606 of Title VI of the Federal Property and Administrative Services Act of 1949, as amended, section 504 of the Rehabilitation Act of 1973, as amended, Title IX of the Education Amendments of 1972, as amended, section 303 of the Age Discrimination Act of 1975, and the Civil Rights Restoration Act of 1987, to the end that no person in the United States shall on the ground of race, color, national origin, sex, or age, or that no otherwise qualified handicapped person shall solely by reason of the handicap, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity for which the donee received Federal assistance from the General Services Administration; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement.

The donee further agrees (1) that this agreement shall be subject in all respects to the provisions of said Federal statutes and regulations, (2) that this agreement obligates the donee for the period during which it retains ownership or possession of the property, (3) that the United States shall have the right to seek judicial enforcement of this agreement, and (4) that this agreement shall be binding upon any successor in interest of the donee and the word "donee" as used herein includes any such successor in interest.

Date

Signature of Authorized Official (Applicant)

APPROVAL/ACCEPTANCE FOR STATE AGENCY USE ONLY

This applicant has been determined: eligible ineligible conditionally eligible
as: a public agency nonprofit education nonprofit health

Account Number: _____ - _____ - _____

Eligibility Expires: _____

Date: _____

CMS Administrator: _____
(Signature)

LENGTH OF ELIGIBILITY GRANTED: _____ YEAR(S)
(Enter on Authorized Representatives page)