

ABILITY® Network Inc. Matching Grants Program Request Form

Instructions

Employee:

- Complete Part A of this form – one for each donation.
- Send this form with your contribution to the recipient organization. If possible, send the form electronically as an email attachment.

Recipient Organization:

- Verify receipt of gift.
- Complete Part B of this form. If possible, complete the form electronically.
- If this is your first matching gift request to the ABILITY Network Program, please include with your submission a copy of your Internal Revenue Service 501(c)(3) determination letter and a brief description of your organization’s mission statement or purpose.
- Submit the form electronically using the Send Request button below.

Part A – Employee Section

Employee Name

Home Street Address

Home City/State/ZIP

Business phone number

Business email address

Exact date gift was made

Amount of gift (min \$25)	Amount to be matched (min \$25, max \$250)
\$ _____	\$ _____

Type of gift (select one): Check _____ Credit Card _____

Name of organization receiving gift

Organization’s operating city and state

I certify that my donation is a voluntary contribution, paid by check or credit card, and not merely pledged. I verify that these are my own resources, not the collected donation or loans of any other person or organization and this is a single donation, not an aggregation of contributions. I certify that neither my family nor I will derive any direct or indirect financial or material benefit from this contribution and that it does not represent, in any way, a fee for a service or benefit. I have read and understand the guidelines of the ABILITY Network Matching Grants Program and I certify that my donation fully complies with its provisions.

Donor signature _____ Date _____

Part B – Charitable Organization Section

Organization Tax ID

Organization Name

Street Address

City/State/ZIP

Primary phone number

Primary email address

Organization website

Date gift received

Amount of gift	Tax deductible amount of gift
\$ _____	\$ _____

I verify receipt of the charitable gift described by the donor, and I hereby certify that this is a non-profit organization/program, and that contributions to it are tax-deductible under Section 501(c)(3) of the Internal Revenue Code. Neither the donor nor ABILITY Network Inc. will derive any personal material benefit from this gift or match. I understand that Matching grants will be processed quarterly at the end of the 2nd month of the quarter (May, August, November). Grants will be paid out within 30 days of the processing period. Submissions received in December will be processed the following calendar year. ABILITY Network Inc. reserves the right to deny any matching grant request. If denied, ABILITY will notify the donor.

Authorized officer’s name

Title

Signature of authorized officer _____ Date _____

If unable to submit at left:
 Print and mail form to:
 ABILITY Network Inc.
 Attn: Communications
 200 N 6th St, Suite 900A
 Minneapolis, MN 55403
 Or save and attach in an email to:
 Communications@ABILITYNetwork.com