



Dream Fund Application

application number (office use only):

Date:

Send to: PO Box 224, East Machias, Maine 04630

fax: 207 835 4500

The Dream Fund helps providers from CCC partner agencies access resources to help clients with children with financial barriers reach their dreams. Applications need to be submitted by staff providers and all communication is between the provider and the Dream Fund Committee.

General Information

Provider Name: _____ Provider agency: _____

Provider email: _____ Provider Phone: _____

Client / Family Name: _____

Client / Family Physical Address: _____

City: _____ Zip: _____

Age(s) of child(ren)(must be between 5 and 18 years old): _____
child 1 child 2 child 3 child 4

Request / Dream Information

Please provide a brief family history and describe the dream:

Resources available that currently support this dream: (please be specific)

Scholarships _____ Transportation: _____
Equipment _____ Uniform _____
Instructor/mentor/coach _____ Other agency support _____
Supplies _____ Other _____



How can the funding make a difference to the child(ren)? (please check all that apply)

- Checkboxes for: Promotes Resiliency, Supports their passion, Increases physical activity, Supports positive relationships with peers, Supports positive relationships with caring adults, Increases access to nature, Increases access to arts and culture, Increases access to fun, Promotes joy, Other

Please categorize your request according to the following areas:

- Checkboxes for: Supplies & equipment, Lessons (how many), Camps/programs (dates), Travel expenses (gas, meals, etc.), Other expenses

Additional Documentation

- All requests must include supporting materials showing the cost or an estimate of the costs for this dream (e.g., an estimate, advertisement or brochure outlining the fees).
• If combining Dream Fund with other resources, you must fill out the Combined Funding Budget on page 3.
• Share any information you think the committee should know when making a determination:

Two horizontal lines for providing additional documentation.

Payment Information

(must be completed)

Vendor / Instructor/ Organization: _____

Address: _____

City: _____ Zip: _____



Contact for follow-up survey

Dream Fund recipients are invited to complete and return a survey which will help the CCC capture the actual impact of the Dream Fund. The survey will be mailed out within 3 months after the funds have been disbursed.

Parent / Guardian Signature:

Date: _____

Provider Signature:

Date: _____

Thank you for your application

Combined Funding Budget

Only fill in the line items that apply to this request / dream. Total costs must equal total funding.

Costs

- Supplies & equipment \$ _____
- Fees (for camp, etc.) \$ _____
- Transportation \$ _____
- Other \$ _____
- TOTAL COSTS** \$ _____

Funding Sources

- Dream Fund Request \$ _____
- Other Agency Support \$ _____
- Savings \$ _____
- Family Contribution \$ _____
- Other \$ _____
- TOTAL FUNDING** \$ _____
- (must equal total costs)