

SAN FERNANDO PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR BUSINESSES PROGRAM APPLICATION

Community Development Block Grant CARES Act (CDBG-CV)

BUSINESS INFORMATION

BUSINESS NAME

BUSINESS ADDRESS

BUSINESS PHONE NO.

BUSINESS EMAIL

BUSINESS OWNER(S) FULL NAME(S)

BUSINESS OWNER(S) PHONE NO.

TYPE OF BUSINESS

WHAT GOODS/SERVICES DO YOU PROVIDE?

NUMBER OF EMPLOYEES
THAT REQUIRE PPE

DOES YOUR BUSINESS HAVE A GROUND-
FLOOR COMMERCIAL STOREFRONT?

☐ YES

☐ NO

DOES YOUR BUSINESS HAVE A CURRENT SAN FERNANDO BUSINESS
LICENSE?

☐ YES; BUSINESS LICENSE NO: _____ ☐ NO

PLEASE PROVIDE A NARRATIVE ON HOW COVID-19 HAS IMPACTED YOUR BUSINESS, AND HOW RECEIVING PPE WILL BE OF ASSISTANCE.

REPORTING *This is a Federally-funded Program. For reporting purposes only, please provide the following demographic information for the business owner.*

	RACE CATEGORIES	CHECK ONLY ONE RACE CATEGORY	CHECK IF ALSO HISPANIC
1	American Indian or Alaska Native	<input type="checkbox"/>	<input type="checkbox"/>
2	Asian	<input type="checkbox"/>	<input type="checkbox"/>
3	Black or African American	<input type="checkbox"/>	<input type="checkbox"/>
4	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
5	White	<input type="checkbox"/>	<input type="checkbox"/>
6	American Indian or Alaska Native and White	<input type="checkbox"/>	<input type="checkbox"/>
7	Asian and White	<input type="checkbox"/>	<input type="checkbox"/>
8	Black or African American and White	<input type="checkbox"/>	<input type="checkbox"/>
9	American Indian or Alaska Native and Black or African American	<input type="checkbox"/>	<input type="checkbox"/>
10	Balance/Other	<input type="checkbox"/>	<input type="checkbox"/>

ACKNOWLEDGEMENT *I/We HEREBY CERTIFY that the information provided in this application are true and correct. Furthermore, if approved, I/we will provide additional documentation and certification of the information provided on the application form prior to grant issuance. I/We will be liable for all costs incurred through the program if any information provided is determined to be false and/or incorrect which may have initially qualified me/us for the PPE Business Program.*

BUSINESS OWNER NAME	SIGNATURE	DATE
CO-BUSINESS OWNER NAME	SIGNATURE	DATE