Health Care Response /COVID-19 Minnesota Fund Request Form

Please complete this form in accordance with the instructions

Agency/Program/Activity: ______________________________

Title of Request: ______________________________

Date: ____________________ **Amount Requested:** ____________________

Request Funding Source:

Health Care Response Fund Request **COVID-19 Minnesota Fund Request**

Brief Summary of Request:

Summary must be complete on this page with supporting information attached.

____
Department Head Signature

____
Date

Form: 7265-01 (March 2020)