



EPIPHANY APPLICATION

P.O Box 7030 Indianapolis, IN 46207

Fax: 317.635.6534



Congregation Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Ethnicity (~%): ___ C ___ AF-A ___ H ___ AS-A ___ O

*It was voted to request the Epiphany service of Hope Partnership. We agree to pay the fee of **\$7,400.00** for this service which will be invoiced at the time of the assessment. Payment will be due 30 days after Experience I.*

We also agree to pay reasonable costs for our assessor's and facilitator's travel and maintenance (avg. \$2500 total).

Authorized Signature: _____ Date: _____

A church's decision to cancel/postpone the service after submitting this request may result in a \$500 cancellation charge if travel reservations have already been purchased.

Setting up the Assessment:

Assessments run from 3:00-9:00PM. ***Date must be at least 4 weeks from the date of application.***

(Please give a few different weekdays when church leaders would be available to attend)

We would like to request the Assessment be done one of these weekdays: _____

Setting up Experience I Retreat (Leadership Training):

Experience I happens on a Saturday and Sunday. Please provide a couple of choices at least six weeks after the Assessment.

We would like to request Experience I occur one of these weekends: _____

Experience II (Future Story Retreat) will be scheduled with your Facilitator at Experience I and will take place 6 weeks to 3 months after Experience I, also on a Saturday/Sunday.

Clergy information:

Name: _____ Position at Church: _____

Email: _____ Phone Number: _____

Who will be your congregation's primary contact person regarding this service?

Name: _____ Position at Church: _____

Email: _____ Phone Number: _____

Official use only:
Date received: _____
Invoice Date: _____
Invoice number: _____