



ATTN: Application Committee
 PO Box 213
 Richland Center, WI 53581
 (608) 604-2900
 www.walkwithgrace.com

Application Form

Name _____ Phone _____

Address: _____ Zip Code _____

County _____ Township _____

Physician _____ Diagnosis _____

 Recipient Name (Please Print)

 Board Member Name (Please Print)

 Recipient Signature

 Board Member Signature

 Date

 Date

 Board Action

| | I have Insurance or Other Assistance | | I need GRACE Assistance | | How Much Financial Assistance is Needed per Month |
|---------------|--------------------------------------|----|-------------------------|----|---|
| | Yes | No | Yes | No | \$ _____ |
| HEATING FUEL | Yes | No | Yes | No | \$ _____ |
| GROCERIES | Yes | No | Yes | No | \$ _____ |
| MEDICINE | Yes | No | Yes | No | \$ _____ |
| MEDICAL COSTS | Yes | No | Yes | No | \$ _____ |
| CAR FUEL | Yes | No | Yes | No | \$ _____ |

OTHER NEEDS
 (* Please Explain *)

I do business at the following:

| | |
|---------------------|--------------------|
| Heating Fuel _____ | Groceries _____ |
| Medicine _____ | Gas Vouchers _____ |
| Medical Costs _____ | Other _____ |

Request for Assistance: Please explain in detail what you are asking GRACE to help with. Include details of what assistance you are currently getting, (Use additional Pages if necessary):

Please be very specific about why you need the financial assistance and what sort of help you are looking for. Please provide additional pages if needed to make your request for assistance.