



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

Application Form

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
 County \_\_\_\_\_ Township \_\_\_\_\_  
 Physician \_\_\_\_\_ Diagnosis \_\_\_\_\_

Recipient Name (Please Print) _____  Recipient Signature _____  Date _____	Board Member Name (Please Print) _____  Board Member Signature _____ Date _____  Board Action _____
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	I have Insurance Or other Assistance		I need GRACE Assistance		How Much Financial Assistance is Needed per Month
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	\$ _____

HAVE YOU PREVIOUSLY RECEIVED G.R.A.C.E ASSISTANCE      Yes      No      If so, when \_\_\_\_\_  
 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 G.R.A.C.E 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.