



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
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.