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

Application Form

Name___________________________ D.O.B.___________Phone ____________________

Address____Zip Code____________________

County ____Township____________________

Physician______________________________Diagnosis______________________________

____
Recipient Name (please print)

____
Recipient Signature

____
Date

FOR OFFICE USE	Case approvals
Diagnosis confirmed	Date
Motion by Board	Date and time
Second by Board	Date and time
Third by Board	Date and time

	I have insurance or other assistance	I need GRACE assistance	How much financial assistance is needed per month
Heating Fuel	Yes or No	Yes or No	$
Groceries	Yes or No	Yes or No	
Medicine	Yes or No	Yes or No	
Medical Costs	Yes or No	Yes or No	
Car Fuel	Yes or No	Yes or No	

Have you previously received G.R.A.C.E. assistance? Yes or No If so, when?

Other needs: (please explain)

I do business at the following: Heating Fuel____________________Groceries________________

Medicine______________________Gas ____________________

Medical ______________________Other__________________

Requests 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)

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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.