



The Family Fund . . . through Marcel's Way
 P.O. Box 392 New Boston, NH 03070 (877) 412-4141 www.marcelsway.org

Grant Request Application (please type or print clearly)

Applicants Name: _____ Telephone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Male _____ Female _____ S.S.# _____

Number of Family Members in Applicants Household _____ Number of Minor Children _____

Medical Diagnosis: _____

Please submit a separate physician's diagnosis and recommendation of the service or equipment requested with this application.

Is someone legally responsible for the Applicant? Yes _____ No _____ Relationship to Applicant _____

Name: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code: _____ S.S.# _____

Describe the equipment or service requested in this application _____

Estimated Cost: _____

List Funds Available for the Equipment or Service

Place a check mark by the Current Family Income from ALL sources (Salary, Disability, SSDI, Child Support, Alimony, etc.)

From Applicant and family members \$ _____ \$2,000 or less per month (\$24,000 or less per year) _____

From Insurance, Medicare and Medicaid, and any other sources \$ _____ \$2,000 - \$4,000 per month (\$24,000 - \$48,000 per year) _____

\$4,000 or more per month (\$48,000 or more per year) _____

Total Funds Available \$ _____

How Much Money Are You Requesting From the Family Fund? \$ _____

I certify that the information provided in this grant application is true, complete and accurate.

Signature of Applicant _____ Date: _____

Signature and Telephone Number of Preparer _____ Phone: _____