THE SECOND Wind FOR LIFE INITIATIVE

RCVD: ____/____/____ Processor_____
Initials
☐Email ☐Fax ☐Telephone Intake

THE WINDMILL FUND 2014 APPLICATION

To Be Filled Out By Social Worker/Medical Personnel

Submission Date _____/_____/_____ Hospital/Treatment Facility_____
Applicant Name _____ County_____
Diagnosis _____ City _____State_____
Date of Diagnosis _____/_____/_____ Treating Physician_____

Social Worker/Medical Personnel:_____
Title:_____
Phone _____ Fax _____ Email Address _____

Please Circle Yes or No

Is Applicant:
U.S. citizen? ☐Yes ☐No Currently going through treatment? ☐Yes ☐No Currently employed? ☐Yes ☐No

Has Applicant:
Applied to The Windmill Fund within the past six (6) months? ☐Yes ☐No
Received an Eviction or Disconnection Notice? ☐Yes ☐No

Other:
Does Applicant Have Medical Insurance? ☐Yes ☐No

Applicant **Total** Monthly Income _____Total Amount **$ Requested** by Applicant_____
Copies of applicant's utility bills and/or rental agreement **must be provided *we will not accept handwritten leases *only first and last pages of rental agreement are necessary*

Why should this applicant be considered for a grant?_____
_____

Social Worker/Medical Personnel Signature _____ **Date** _____/_____/_____
Applicant Signature_____ **Date** _____/_____/_____

Is medical facility submitting application within the "open" dates (1st through the 7th of each month)? ☐Yes ☐No

Applications must be emailed to help@secondwindforlife.org OR faxed to 1-855-898-3643

A Different Approach to Health Wholeness

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