**Aging Services Coalition of North Iowa, Inc.**

**One Time Grant Assistance Application**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Please Print. All information must be completed for processing and approval\*\**

**Address**: Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_

**Phone (Home)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**Work/other**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Annual Household income**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Individuals living in the home**: \_\_\_

*(Income limits are based upon current Elderly Waiver guidelines)*

**Please describe your need**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name & Address of Vendor to be paid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*\*A copy of specific bill or estimate must be attached\*\**

**Have you been denied other financial assistance?** \_\_\_ Yes \_\_\_\_ No

**From whom and why?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What other assistance have you received?**

Amount: $\_\_\_\_\_ From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: $\_\_\_\_\_ From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you working with an agency [i.e. Elderbridge, County Services] \_\_\_ Yes \_\_ No**

**If yes, who is the agency contact**:

(Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Ext. #)\_\_\_\_\_\_

**Where did you learn about this grant application?**

\_\_\_ Internet \_\_\_ Radio \_\_\_ TV \_\_\_ Newspaper \_\_\_ Agency [i.e. Elderbridge/County Services] \_\_\_ Medical Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***By signing below, I verify that the above information is correct, and am giving the grant committee permission to review, verify, and/or seek other information on my behalf, for the sole purpose of considering me for an Aging Services Grant.***

Applicant Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMPLETE/SIGN FORM AND MAIL WITH COPY OF VENDOR BILL TO:**

David A. Grooters, Treasurer-Aging Services Coalition of North Iowa, Inc.

103 East State Street - Suite 800

Mason City, IA 50401

FOR OFFICE USE ONLY

Grant Amt:\_\_\_\_\_\_\_\_\_ Check #\_\_\_\_\_\_

Payee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intended Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rev. 8/17