Child's Name Condition ID #

Gracie's Promise

P.O. Box 1366
Torrington, WY 82240

Gracie's Promise Application Package Information

Mission -

The mission of Gracie's Promise is to give financial assistance to families with children, ages birth to 18 years of age, battling catastrophic medical circumstances. Recipients are selected by the Gracie's Promise Board after receiving the COMPLETED application package consisting of the application form, sponsor information, and the child's treating physician form confirming the child's diagnosis (application package download link)

After a decision is made, the applicant will be notified by U.S. Mail. No application is considered without the completed 3 - form package. All information is confidential and will not be disclosed to anyone but board members without written consent.

Requirements - The Application Package

1) A completed and signed application
2) Sponsorship
3) Verification of medical condition by attending doctor

Sponsorship -

The sponsor acts as a major link between the family and the board. This person should not be a member of the immediate household.

The sponsor agrees to keep the board informed as to the status of the child by returning a questionnaire sent 3 times a year. This questionnaire will be sent in time to be returned by the **26th of the month** prior to the next board meeting when continued financial assistance is discussed. **Without this report being returned by the due date, the financial assistance will be tabled until the next meeting.**

Its is also the sponsor's responsibility to keep the board informed of any change of address, email or phone number for either the family or sponsor.

Please return the completed application with sponsor information and doctor's report to:

Gracie's Promise
PO Box 1366
Torrington, WY 82240

Family Application

Child's Name: _____

Family Contact Information

Parent(s) Full Name: _____

Physical Address : _____

Mailing Address : _____

City, State, Zip: _____

Phone Number: Home _____ Work _____ Cell _____

Email: _____

Sponsor Information:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: Home _____ Work _____ Cell _____

Email: _____

Medical Information:

Patient's Full Name: _____ Date of Birth _____

Patient's Condition: _____

Name of Primary Physician: _____

Physician's Address, City, State: _____

_____

Signature of Person completing application

Privacy:

{ } We would like to remain private { } We are willing to share our story.

The above information is accurate and truthful.