NCAC
Northwoods Community Assistance Coalition

Client Information

Client Name_____ Date_____

Street Address _____

City, State, Zip _____

Phone Number _____ Email Address _____

Household size _____ Number of dependent children living at home _____

Disability _____

Veteran No ☐ Yes ☐ (If Yes, please attach a copy of your DD-214)

Request need: Financial ☐ Wheelchair Ramp ☐ Medical Assistance ☐ Other ☐

Date assistance is needed by: _____

Documents Required

Please submit the following documents with this completed form.

☐ A brief written description explaining the financial need and your need for the requested item(s).

☐ Two or more itemized price quotes describing the equipment requested and the name and address of the vendor/contractor.

☐ A written statement and/or prescription from a physician or therapist verifying the medical necessity for this item(s). The documentation should clearly specify the need for the equipment and benefits of use.

May 21, 2024

☐ Documentation of monthly household income. If you filed taxes, you must include a copy of page 1 & 2 of your most recent 1040 tax forms. If you do not file taxes, please include a copy of your social security statement (SSI, SSDI)

Documentation for Home Accessibility Modification Request Only

☐ A copy of the most recent property tax bill

☐ Proof of Homeowner's Insurance

☐ Letter from the homeowner stating that they will allow NCAC to make the requested modification to the property (if the home is owned by someone other than the client).

Assistance Request

Have you contacted any of the following agencies to assist with your request?

☐ Yes ☐ No Medial Assistance or Medicaid Amount contributed _____

☐ Yes ☐ No Insurance – Company Name _____

Amount contributed _____

☐ Yes ☐ No Community Options Program or Community Integration Program

Amount contributed _____

☐ Yes ☐ No Family Support Program/other county funding Amount contributed _____

☐ Yes ☐ No Division of Vocational Rehabilitation Amount contributed _____

☐ Yes ☐ No Options of Independent Living - Green Bay Amount contributed _____

☐ Yes ☐ No Aging Disability Resource Centers Amount contributed _____

☐ Yes ☐ No Veterans Affairs Amount contributed _____

☐ Yes ☐ No Other (such as service organizations) Amount contributed _____

Portion you are able to contribute (if any) _____

Signature: _____ **Date:** _____

For Office Use Only

Recommended by _____ ☐ Approved ☐ Denied

Total Cost _____ Client/Other Contributions _____ NCAC Contribution _____

Date _____

Authorized Signature _____

Payee _____

Send to _____

Dollar Amount _____ Account Number _____

Check # _____ Date _____