

**FRED J. and RUTH HEFLIN COFER FOUNDATION
GRANT APPLICATION**

APPLICANT INFORMATION

Name		<table border="1"> <tr> <td>Name of Person with need if different than applicant</td> </tr> <tr> <td>Relationship to Applicant</td> </tr> </table>	Name of Person with need if different than applicant	Relationship to Applicant
Name of Person with need if different than applicant				
Relationship to Applicant				
Address1				
Address2				
City				
State				
Zip Code				
Home Phone				
Cell Phone				

Description of Need (Please provide specific information about your request)	
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Event or condition that created the need:	
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Event Type (Check all that apply)	<input type="checkbox"/> Special Need for an Individual who is physically challenged
	<input type="checkbox"/> Special Need that will not be met through public or private means

Physician Information (Primary Physician and Specialist Physician)

Physician Name	
Physician Phone	
Specialist Name	
Specialist Phone	

Immediate Family Information (Include immediate family members living at home or in college)

Number of Adults	
Children 18 or younger	
Children over 18	

Household Income Qualification Information

Household Income (Check One)	
Less than \$20,000	<input type="checkbox"/>
\$20,000-\$35,000	<input type="checkbox"/>
\$35,001-\$50,000	<input type="checkbox"/>
\$50,001-\$75,000	<input type="checkbox"/>
\$75,001-\$90,000	<input type="checkbox"/>
over \$90,000	<input type="checkbox"/>

<p>Mail the completed application to: Fred J & Ruth Heflin Cofer Foundation P.O. Box 1133 Cartersville, GA 30120</p>
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ATTACH ADDITIONAL PAGES TO EXPLAIN YOUR SPECIAL NEED IF DESIRED

Signature of Applicant _____	Office Use Only	
Date	Date of Review	
	Board Action	
	Board Signature	