Name: _____ Date: _____

Gender: Male _____ Female _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Alternate number: _____

Diagnosis: _____ Date of Diagnosis: _____

To help us track our gifting, please describe below how much money you are requesting and what the money would be used for:

_____

_____

_____

_____

How did you hear about Angel Fund? _____

Applicant: self/patient _____
other_____ relation to patient _____

For questions or more information, call 218-362-6668 and leave a message.
We can also be reached via email at info@angelfundrange.org.

To submit this request, send this application to:
Angel Fund, P.O. Box 114, Hibbing, MN 55746

January 2017