

Nursing Facility Transition Grant- Application

Name of Applicant:		Date:
Date of Birth:	Date of Move:	
Transitioning From:	Transitioning To:	
Person completing the form:	Number:	
Agency:	Email:	
Transition Plan Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (if not complete, payment cannot be made)		
Amount Requested: \$		
Describe the items, services or payments requested and attach supporting documentation		
Vendor or Service Provider Name:		
Address:		
Telephone Number:		
Website:		
I certify that the information submitted in this form is true and accurate to the best of my knowledge. It is my understanding that the items or services for which I have requested this grant are not covered by any other funding source.		
Applicant Signature:		Date:
Signature of Legal Guardian:		Date:
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Amount: \$	Date:
NFTG Staff Signature:	Title:	
Comments:		