Country Roads Travel Assistance
Gift Card Request Form

Please complete the information below for Gift Card Requests and return.

Date:_____

Cards Requested By (Caregivers Name): _____
Please select the relationship to the child: Mother_____Father_____Grandparent_____Other_____
Child Name: _____
Name_____(Social Worker or Nurse)
Date Of Birth:_____
County:_____
Patient Phone:_____
Facility_____
Physician_____
Insurance Carrier _____
Diagnosis, Treatment and Duration of Treatment
_____

_____

_____

Country Roads Travel Assistance Program Gas/ Lodging/ Food/

Gift Card(s) requested: Visa- $250

Gift Card Request: Quantity:_____Total $:_____
Tablets:_____Free Donation Apple___Android___
How familiar are you with technology? Do not understand_____Okay but need help_____Need some help but not much_____Very familiar ____ Contact Walking Miracles for a demonstration 304 550 9599.
By signing this request for our Care Assistance Program, I agree that:

- I am responsible for the safekeeping and maintenance of gift cards until distributed to recipient.
- I understand that I am responsible for sending a copy of registration form to walkingmiracles.org so we can use it for our tax purposes and recording the outcome for the grant money received.
- Total Amount is $ 250 twice a year January-August / October–December for a total of $ 500
- **ONLY FOR GAS, FOOD AND LODGING DURING TREATMENT.**

Signature_____(Social Worker)

Signature_____(Caregiver/Survivor)

I give Walking Miracles Family Foundations permission to contact us to discuss further social services offered
Signature_____

Services I am interested in and/ or requesting.

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