

WISCONSIN PARALYZED VETERANS OF AMERICA

FINANCIAL REQUEST FORM

DATE

NAME

ADDRESS

CITY

STATE

ZIP

HOME TELEPHONE #

WORK #

DATE OF BIRTH

NAME AND PLACE OF EVENT

DATE OF EVENT

HOW DOES WPVA BENEFIT?

TOTAL AMOUNT OF REQUEST

REQUEST BREAKDOWN

AIR FARE \$ _____ CAB FARE \$ _____ AUTO RENTAL \$ _____

MILEAGE \$ _____ PARKING \$ _____ LODGING \$ _____

TIPS \$ _____ * PER DIEM \$ _____ OTHER (SPEC.) \$ _____

EXPLANATION

* UP TO 60% OF ROOM RATE/DAY, OR UP TO \$35/DAY, WHICHEVER IS HIGHER OR AGREED UPON.

PERSONAL CARE ATTENDENT (PCA) INFORMATION (MANDATORY)

NAME: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER: (_____) _____ -- _____ DOB ____/____/____

SOCIAL SECURITY NUMBER ____/____/____

PLEDGE & RELEASE OF LIABILITY

I hereby pledge to deliver a typed report and a business expense report (BER) to the WPVA Chapter office within 15 (fifteen) business days of the completion of the event. I understand if I do not complete this requirement, I will not be eligible for future financial assistance from the Wisconsin PVA Chapter until I complete the requirements, submit them, and I am approved by the Board of Directors to again be funded.

SIGNATURE _____ DATE ____/____/____

APPROVING SIGNATURE _____ TITLE _____ DATE ____/____/____