



**Fishing for the Fight**  
**P.O. Box 1038**  
**Pinedale, WY 82941**  
**boardfff@gmail.com**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**(If minor, parent's name)** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Contact Phone Number:** \_\_\_\_\_

**Preferred Method of contact:** \_\_\_\_\_

**Diagnosis Condition:** \_\_\_\_\_

**Resident Years in Sublette County:** \_\_\_\_\_

**How many months do you reside in Sublette County:** \_\_\_\_\_

**Are you a permanent Wyoming Resident:** \_\_\_\_\_

**Total Amount requested:** \_\_\_\_\_

**Briefly Explain the nature of the need at this time (i.e. food, fuel, motel, medical bill not covered by insurance, etc.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is Applicant covered by Private Insurance, Medicare, Medicaid, or Disability Insurance? (list all coverage)**

\_\_\_\_\_  
**Deductible for the above:** \_\_\_\_\_

**Amount covered by all insurance:** \_\_\_\_\_

**I certify to the best of my knowledge all information about to be true and accurate.**

**Patient or Guardian Signature:** \_\_\_\_\_

**Doctor's Signature:** \_\_\_\_\_

**Please Print Doctor's Name:** \_\_\_\_\_

**Hospital or Doctor Address:**

\_\_\_\_\_

\_\_\_\_\_

**Doctor's**

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional Comments from Patient or**

**Guardian:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Requirements for applicants that apply for this assistance.**

**Need**

**Reside in Sublette County**

**Please feel free to attach any documentation or additional pages if needed for explanation, etc.**

**Mail your application to:**

**Fishing for the Fight**

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