



REQUEST FORM

Please Type or Print Clearly

Resident's Name: _____ Age: ____ Gender: M or F

Facility Name: _____

Address: _____

City: _____ State _____ Zip: _____ Phone: _____

Contact Person: Name: _____

Title: _____

Email: _____

Phone: (if different from above) _____

Please briefly describe the wish here and attach up to one typed page of additional information about the wish. Be sure to note if the resident's background relates to the wish and why it is important or significant.

Financial Estimate of Request: \$ _____

Are you aware of any local resources that could potentially assist financially or otherwise with this request? Yes or No

If yes, please explain: _____

Please submit this form by mail, fax or e-mail, or apply online at www.whca.com or www.wical.org:

Wisconsin Health Care Association / Wisconsin Center of Assisted Living
121 E. Wilson Street, Suite L200
Madison, Wisconsin 53703
Phone: 608.257.0125
Fax: 608.257.0025
wishingwell@whca.com