Please note: The Rachel Way provides food only for those individuals with certain food-limiting illnesses, but additional support services are available for the family as a unit.

Name _____

Address _____

City _____ State _____ Zip Code _____

☐ Phone (cell) _____ ☐ Phone (work/home) _____

☐ Email _____

Please check above the best way to contact you.

Number of people living in residence _____

Number of people who require specialty food _____

Please list three (3) grocery stores where you shop:

1. _____ 2. _____ 3. _____

Doctor's diagnosis* (celiac, food allergies) _____

*(*This application is to be submitted along with a doctor's note stating the medical reason gluten free/allergy safe food is needed.)*

I understand that The Rachel Way exists to provide food assistance to individuals and families who really need that help. By accessing help from The Rachel Way pantry I affirm that my household genuinely needs food assistance.

Signature _____ ***Date*** _____

Please note that applying to The Rachel Way does not guarantee service. Funding sources have to be available for services to be rendered.