

Other Financial Assistance Form

(i.e. Chemo, Radiation, Out-of-town housing...)



419-423-0286

Client Name: _____ **Date:** _____

Address: _____ **Phone Number** _____

Description of Need: _____

Staff Comments: _____

Approval: _____ **Date:** _____

Please rate on a scale of 1 (least) to 5 (most), how much this program has assisted you and your family. Circle one: 1 2 3 4 5

CPS Board Members will occasionally contact clients to evaluate their CPS experience.

Please check the box if you are willing to be contacted. Best time to call: _____

<i>Office Use Only</i>	Invoice Approved:	Date of Approval:
Amount Approved:	Approved for Pmt:	General Ledger #: