5195 Hampstead Village Center Way #106
New Albany, Ohio 43054
**FAX:** (614) 855 - 6122

# FINANCIAL ASSISTANCE REQUEST FORM

Date: ____/____/_____

Company Name:
(If Applicable)

Person Making This Request:

Address:

City, State, Zip:

Phone: (   )   -

Fax: (   )   -

Email:

---

Reason for Contact:
- ☐ Financial Assistance Program
- ☐ Deductible Assistance Program
- ☐ Special Request ___________________________________

*Name of physician:______________________________________________________

Contact phone number: (   ) _______-________

*Name of allied medical services provider:___________________________________

Contact phone number: (   ) _______-________

Number of people in your immediate family: _______

Annual family income: $_________

Please provide a brief background, description of the circumstances and reason for your request:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Applicant represents that the information being provided to Children's Body-Image Foundation is true and accurate to the best of the Applicant's ability. The Applicant also understands and acknowledges that Children's Body-Image Foundation will rely on this information in its determination whether or not to provide assistance. Applicant further understands that he or she may be required to submit proof of income up to and including copies of recent tax returns.

Signature: ___________________________________ Date: ____/____/_____

Print name: ___________________________________

*Please print this form and fill it out and fax it to the number listed above.

---

**(CBIF Office Use):**

**Date Received**: ____/____/______ **Assigned Case #**: ___________________

**Approved**: Yes/No **If No, Give Reason**: _______________________________

**If Yes, Check #**___________ **Amount**: $____________

---