MAPS Charities
14320 Ventura Blvd., #331
Sherman Oaks, CA 91423
Email: intake@mapscharities.org
FAX: 661-296-6732

REQUEST FOR ASSISTANCE

Review Guidelines and Instructions prior to completing request

Completed application, estimates and/or invoices: **Scan and email to: intake@mapscharities.org** or fax it to (661) 296-6732.

Amount of Request $_____ **Type of Service Requested:** _____

Service Provider/Store Name: _____

Request Date: _____

Referral Agency Name: _____

PSA Name & Title: Last _____ First_____ Title_____

Address: _____

Email: _____

Phone: Work_____ Cell _____

Client Name: Last_____ First_____ Middle_____

Client Address: _____

Client Phone: _____ **Date of Birth**: Year _____ Month____ Date____

Information is required for grant purposes. **Gender**: (Please Check) ___Male ___ Female ___ Other

Ethnic Origin: __White __Hispanic __African American __Asian/Pacific Islander __Other _____

Please check all that apply: __DME __Vet __Homeless __Holocaust Survivor __Mobility Issues

Summarize specific item(s) or services preferred.
If check, list to whom check is written and include account number.

ITEM/SERVICE	VENDOR (Acct.#, Landlord info)	COST Include fees, taxes, shipping

Include a bill or invoice with Name, Address, Account Number, and Phone Number for Check Recipient. Confirm that a third-party check will be acceptable to the Check Recipient.

MAPS CHARITIES REQUEST FOR ASSISTANCE (PAGE 2 OF 2)

ASSESSMENT OF CLIENT NEED AND CIRCUMSTANCES (use separate paper if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Assessment Date: _____ Location of Assessment:_____

How long have you known this person? ___ Year(s) ___ Month(s) ___ Week(s) ___ Day(s)

PSA Certification

I certify that I have verified, to the best of my ability, that the information on this form provided to me by the Client is true and accurate.
NAME OF CLIENT: _____
has authorized me to make this request on their behalf. The Client understands that their name will appear on orders, checks and forms for purposes of identification. MAPS Charities may use this information for promotional purposes or for use in telling the MAPS Charities' story without using the client's name.

PSA Signature: _____ Date: _____

You agree, if used, your electronic signature is the legal equivalent of your manual signature on this Request.

Applications must be received by the week prior to that month's board meeting. Please check MAPSCharities.org for current board dates.