**The Rady Lady Foundation, Inc.**

**Financial Need Form**

Legal Name: \_\_ \_\_\_\_\_

 First Middle/Maiden Last

Date of Birth: / / Best Contact (Cell/Home Phone):

 MM DD Year

Street Address: City:

State: Zip Code:

Email Address:

Next of Kin or other Contact Name:

Best Contact (Cell/Home Phone):

Situation or Illness:

Date diagnosed or date of hardship:

(Complete if diagnosis/illness)

Physician:

Physician Office Address:

Office Phone:

Provide Household Income: / Year

# Family Members in Household:

Explain Financial Need and Provide Copy of Bill/Invoice:

My signature affirms that all contents of this form is current and accurate, and as necessary, the Foundation will confirm with my physician (physician’s office staff) or otherwise my diagnosis/need.

 Print Name Signature

 Mail to: The Rady Lady Foundation, Inc.

 Date 1484 Allen Ct. Asheboro, NC 27205