



# DISASTER ASSISTANCE REQUEST FORM

## Contact Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Explanation of Why Disaster Assistance is Being Requested (*Please be specific*): \_\_\_\_\_

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Supplies Needed (*Please be specific*): \_\_\_\_\_

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Alternative Assistance Needed (*Please be specific*): \_\_\_\_\_

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Work (Shipping) Address: \_\_\_\_\_

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Employer Contact Information (Supervisor Name, Company & Phone Number):

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Have any Benefits Been Applied for with Any Other Organization? If Yes, Please List Here:

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**SUBMIT TO:**  
**COLLISION INDUSTRY FOUNDATION**  
**P.O. BOX 3007, MECHANICSVILLE, VA 23116**  
**PH: 888-667-7433 / 804-427-6982**  
**FAX: 866-498-7433 / 804-427-6982**

-----OFFICE USE ONLY-----

PLACEMENT SPECIALIST: \_\_\_\_\_ TOTAL AMOUNT REQUESTED: \_\_\_\_\_

Disbursement Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Check Number: \_\_\_\_\_ For: \_\_\_\_\_

Disbursement Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Check Number: \_\_\_\_\_ For: \_\_\_\_\_

Disbursement Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Check Number: \_\_\_\_\_ For: \_\_\_\_\_

Notes: \_\_\_\_\_

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