**Flagler Cares Barrier Removal Fund Impact Form**

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| **Date** |  |
| **Client’s Name** |  |
| **Organization that Applied for Assistance on Client’s Behalf** |  |

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| **Please describe the assistance that the client received from the Flagler Cares Barrier Removal Fund.** |
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| **Please describe how this assistance helped the client remove barriers to health and stability.** |
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| **Other notes or information you would like to share? If possible, we would appreciate a quote from the client who received assistance.** |
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Please return completed form to help@flaglercares.org