STATEMENT OF FINANCIAL NEED

Client Name *(Person to be tested)*: _____

DOB: _____ **Grade:** _____
(mm/dd/yy)

As an agent of _____, I verify that
Non-Profit Agency / School

_____ exhibits financial need which would otherwise prevent
Parent/Guardian Name

them from being able to pay the full cost for the independent education tested provided by LinkED.

☐ I attest that a parent/guardian has been contacted and has authorized me to share this information with LinkED.

☐ Our organization will provide additional funding to help offset any remaining balance or cost for testing. These payment(s) will be made with:

Cash ☐ Check ☐ Credit Card ☐

_____ _____
Signature Agency Title

_____
Date (mm/dd/yy)

The following individual will serve as our agency point of contact with LinkED:

_____
Name

_____ _____
Phone Email