P.O Box 161351,Altamonte Springs, FL 32716-1351
407-262-2141/FAX: 407-936-2001

# REQUEST FOR FINANCIAL ASSISTANCE

**REQUESTOR INFORMATION:**

Name: _____Agency: _____

DATE: _____

Phone: _____Email:_____

Agency Approval:_____

**OTHER RESOURCES AVAILABLE:**

| | |
|---|---|
| Parents and other relatives | † Yes † No |
| Child Welfare Funds | † Yes † No |
| ( DCF, S.S.I., F.S.P.T., W.I.C., Medicaid, Master Trust Funds) | |
| Other Non-profits | † Yes † No |
| (CBC, Foundation for Foster Care, Intervention Services, etc.) | |

If request was made and denied, please state reason:_____
_____
_____

**YOUTH'S INFORMATION: CASE NO: _____**

First Name: _____ Last Name: _____

Age: _____ Gender: _____ School: _____ Grade: _____

Placement: † Foster Home † Relative † Group Care † Other:_____

BRIEF SUMMARY OF CHILD'S HISTORY AND NEEDS: (use additional sheet of paper if necessary)
_____
_____
_____
_____

DOLLAR AMOUNT NEEDED: _____ † Activity † One Time † On-Going

PURPOSE: MEDICAL/DENTAL ___ GIFT____ CLOTHING___ TRANSPORTATION _____ OTHER_____

**Please note that clothing requests will be given in the following age group categories. Shoes are considered a clothing item**
**Ages 0 – 10yrs old will be in the amount of $100.00 Ages 11-18yrs old will be in the amount of $150.00**

† TUTORING Subjects: _____† In Home † Learning Center Provider: _____

***PLEASE ATTACH STATEMENTS/QUOTES TO REQUEST***

Make Check payable to: _____ Total Amount of Check: _____
Address: _____
_____

(To be completed by Officer of SCFAC Board)

APPROVED BY: _____
TITLE: _____
DATE: _____

*Incomplete requests cannot be processed. We do not reimburse without previous authorization. Processing usually takes 10 days or less. By submitting this request to SCFAC you are verifying that no state funding or other resources are available to fund this request. If further information is needed, the requestor will be contacted.*