|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: | | | DOB: | | | | DSS # (if known): | | | |
| SW Name: | | | Phone Number: | | | | | | | |
| Caregiver’s Name: | | | Phone Number: | | | | | | | |
| **Requestor Information (if different than the youth or social worker named above)** | | | | | | | | | | |
| **Name:** | **Agency/Relationship to Child:** | | | | | **Phone Number:** | | | | |
| **Address:** | **City:** | | | | | **State:** | | | **Zip:** | |
| **Request reviewed by:** | Social Worker | | | | Caregiver | Youth | | | | None |
| **Item/Activity Being Requested\*\*** | | | | | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Camp |  | Lessons |  | Sports Team |  | Items to support independent living goals | |  | School Extra-curricular Activity |  | Travel |  | Other |  | Items to support participation in any of the above activities | |  | Self-Care or Enhancement products not covered by foster care (ie. culturally significant items or products, hair/nail salon appointments, other body/beauty care products, etc) | | | | | | | | | Description of item/activity and how it supports the youth’s well-being (including start and end dates for travel, camps, lessons, or other structured activities): | | | | | | | | |  |  |  | | --- | --- | | Has the youth received Enrichment Funds prior to this request? | No  Yes: Date and amount |   **\*\*NOTE: If the item/activity requested requires Juvenile Court authorization, please ensure you have the court approval prior to submitting the request.**   |  | | --- | | **Payee Information** | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | One-Time Cost |  | Ongoing Payment: Frequency of Payment | | | |  | Pre-payment to a business/organization |  | Reimbursement to caregiver |  | Reimbursement to youth |   Cost for the Activity/Item:       (All travel requests and all activity/item costs over $500 require pre-approval) | | | | | | | | | | |
| Make Check Payable To: | | | | Phone: | | | | | | |
| Address: | | City: | | State: | | | | Zip: | | |
| Mailing Address for Check (if different from above): | | | | | | | | | | |
|  | | | | | | | | | | |

Submit request and proof of purchase, bill, or invoice to [CFWBFamilyFlexFunds.HHSA@sdcounty.ca.gov](mailto:CFWBFamilyFlexFunds.HHSA@sdcounty.ca.gov) and the youth’s social worker. Approval and money distribution can take up to 6 weeks.

|  |
| --- |
| **Authorization for County Payment** |

Payee Name:       Payment Amount $:       Date of Service:

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:

Reviewed by Policy Analyst:       Date: