|  |  |  |
| --- | --- | --- |
| 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.**

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| --- |
| **Payee Information** |

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| --- | --- | --- | --- |
| [ ]  | 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 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: