****

Total Amount of check:

$

County:

\_\_\_\_\_\_\_\_\_\_\_\_\_

Alliance Use Only

Check #

Check Date

Cashed on

Verified by:

**Child Flexible Funds Request Form**

*Please submit a typed request*

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child/young adult (up to age 21) |  | CFT Coordinator’s Name |  |
| Child’s Date of Birth |  | Phone Number |  |
| Parents/Guardians |  | Agency Name |  |
|  |  | CFT Coordinator’s Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Item & Total Cost of Service/Goods |  | Vendor Name (this is the name of the agency that the check will be mailed to) |  |
| Family Contribution |  | Vendor Address |  |
| Community Partner Contribution |  | City, State, Zip |  |
| Total Amount of Flex Funds being requested |  | Vendor Phone Number |  |
| Revised PCP, ISP, or outpatient treatment plan uploaded into Alpha(Yes or No)  |  | Vendor Contact Person’s Name  |  |
| Is vendor willing to accept check from Alliance? Yes or no |  | Are vendor’s valid W-9 and Vendor Profile Form attached to request? (both are required) |  |

1. **Whenever possible, the proposal should include contributions from the family and a community partner. If contributions from the family and/or a community partner are not included, please explain why:**
2. **Reason for Request (please include (1) how the service/goods being requested will help meet the service needs of the child/young adult and/or family and (2) what other revenue sources were considered, pursued, and ruled out):**

**APPROVAL**

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CFT Facilitator/Care Coordinator Date Parent/Legal Guardian Date

Alliance System of Care Coordinator Date Community Engagement Manager Date