DCF REGION: ____________ SERVICE COUNTY: ____________

PROVIDER: ____________

REQUESTOR			
NAME *(F, MI., L)*:		SSN:	
ADDRESS:		DOB:	
CITY:	ZIP:	RACE:	
COUNTY OF RESIDENCE:		GENDER *(M/F)*:	

SERVICE INFORMATION		VENDOR INFORMATION
START DATE:		COMPANY:
END DATE:		ADDRESS:
AMOUNT:		CITY: ST: ZIP:
		FEIN OR SSN:

DCF AGENCY INFORMATION			
PPS STAFF NAME:		DATE:	
PHONE:		EMAIL:	
PPS SUPERVISOR AUTHORIZATION:			
Supervisor or designee shall review page 3 prior to authorization:			
☐ Approved ☐ Not approved			
SUPERVISOR SIGNATURE:		DATE:	

Note: If a copy of the invoice or PO is to be attached to the payment, please include the needed documentation with this form. All requests for utility payments must include a copy of the outstanding bill.

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FOR PROVIDER USE ONLY:

________ **DATE REC'D**

________ **ENTERED INTO SPREADSHEET**

________ **DATE GIVEN TO A/P**

________ **CK DATE & AMOUNT**

****

****SEND ONLY PAGE 1 TO PROVIDER****

Page 2 is intentionally left blank

*****PAGE 3 IS FOR PPS USE AND IS NOT TO BE SENT TO THE PROVIDER*****

DCF AUTHORIZATION *The following factors shall be considered prior to authorization of flex funds.*
Describe the specific need(s) of the family (i.e. what specifically happened, for example, loss of job, illness, unexpected expenses, etc., which brings the family to the agency to request the flex funding?):

				IF YES:	
Has the family received funding in the past?	Y	N	UK	Describe:	
Will the family be able to meet this need next month, or future months? *(For example, if flex funds pays for utilities, how will the family be able to pay next month and beyond?)*	Y	N	UK	Describe:	
Does the family receive other DCF services?	Y	N	UK	List other(s):