HEALTH SYSTEMS

Incidental Expenses
Request/Approval Form

Agency: _____ Staff Name: _____ Date: _____

Section A.: Request for Service Funding Authorization

1. Client Name _____ 2. SSN _____

3. DOB _____ 4. Program: _____ 5. Sex: M F 6. Yearly Income _____

7. Description of Goods/Services requested: _____

_____

_____

8. General reason for request/benefit to participant: _____

_____

_____

9. Alternatives explored (detail agencies and outcomes): _____

_____

_____

10. List 3 quotes from different companies: 1st Company Name: _____ Price Quote: _____

2nd Company Name: _____ Price Quote: _____

3rd Company Name: _____ Price Quote: _____

11. Funding amount requested: _____

12. Itemization of the funding amount requested:

Item:	Amount/Price

For each item listed above, please include supporting documentation (i.e., invoice, estimate, past due notice, etc.)

13. Vendor (Name, Address, and Vendor ID#) _____

_____ _____

Staff Signature/Date Supervisor's Signature

Section B. Action Taken *(to be completed by LSFHS)*

Request Approved: _____

Request Disapproved: _____

Instructions or Reason for Disapproval: _____

_____

Acknowledgement of request from Provider to access Incidental Expenses Funds

_____

LSFHS Network Manager Signature/Date

_____ _____

LSFHS Second Approver Signature/Date LSFHS Second Approver Title