HEALTH SYSTEMS

Incidental Expenses
Request/Approval Form

(Required for requests over $1,000)

Agency: _____ Staff Name: _____ Date: _____

Section A.: Request for Service Funding Authorization

1. Client Name: _____ 2. SSN: _____

3. DOB: _____ 4. Program: _____ 5. Sex: M ○ or 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., treatment plan, invoice, estimate, past due notice, etc.)

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

_____

_____

_____ _____

Staff Signature/Date Supervisor's Signature/Date

*Submit this completed **and** signed form with supporting documentation through LSFHS Data System for final Managing Entity review and approval.*