Durham Center Use Only Check #_____ Check Date_____ Cashed on_____ Verified by:_____

THE DURHAM CENTER
Managing Behavioral Health & Disability Services

Total Amount of check: $

System of Care Flexible Funds Request Form

Name of Child		CFT Coordinator's Name	
Parents/Guardians		Phone Number	
Phone Number		Agency Name	
		CFT Coordinator's Email	

Total Cost of Purchase	$	Vendor Name	
Personal Contribution*	$	Vendor Address	
Community Contribution*	$	City, State, Zip	
Total Amount of Request	$	Vendor Phone Number	
		Vendor Contact Name	

*** Whenever possible, the proposal should include contributions from the family and a community partner.**

Reason for Request:
[Address following: Describe the need that this will meet/how this fits with the child's PCP; attach a list of other community resources pursued; if the request is to resolve a financial issue that the family has, explain how the situation developed and what steps the family will take to avoid the same from happening again.]

APPROVAL

CFT Facilitator/Case Manager Date

Parent/Legal Guardian Date

Child Specialist Date

Secondary Approval Date

Created 9/5/08