TANF CONTINGENCY FUNDING REQUEST FORM

CLIENT INFORMATION

Client Name: _____ DOB: _____ SS #: _____

PROVIDER INFORMATION

Provider Name: _____ Contact Person: _____

Contact Number: _____ Email: _____

REQUEST FOR SERVICE FUNDING

Funding amount requested: $ _____

Description of goods/services requested: _____
_____
_____

General reason for request/benefit to client : _____
_____
_____

Alternatives explored: _____
_____
_____

Vendor Name	Vendor Address	Vendor ID#

Client was asked and acknowledged that they have not previously been recipient of services funded by TANF one-time payment/contingency.

_____ _____

Provider Representative Signature **Date**

TO BE COMPLETED BY CENTRAL FLORIDA CARES:

One-time payment request: ☐ Approved ☐ Denied

Amount approved: $ _____

Reason for denial: _____
_____

TANF Specialist Signature: _____ **Date:** _____

TANF Contract Manager Signature: _____ **Date:** _____