Voices for Children of NC Florida, Inc.
Request for Assistance

Please Print

Date _____ Amount Requested _____Case No.: _____County: _____

GAL Name: _____ Phone #: _____Email: _____

Make check payable to:_____

Name and address check should be mailed to:

_____

_____

What alternate resources have been pursued?_____

_____

Name of Person You Contacted_____

CAM Printed Name: _____ Signature: _____

CAM's Phone No.: _____

Placement of Child: Foster Care ☐ Family ☐ Group Home ☐ Other: _____

Is this request to support or to deny reunification? _____ N/A ☐
Has this been ordered by the court? Yes ☐ No ☐
Please provide item or service being requested and reason and details about request.

_____

_____

_____

_____

_____

First name ONLY, age, sex of child(dren):

Name: _____Age: _____Sex: _____
Name: _____Age: _____Sex: _____
Name: _____Age: _____Sex: _____
Name: _____Age: _____Sex: _____
Name: _____Age: _____Sex: _____
Name: _____Age: _____Sex: _____
Name: _____Age: _____Sex: _____

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Treasurer's Use Only

Date Approved: _____Denied: _____ Why_____

_____

Check #_____ Date Issued: _____

Date Receipts Received: _____

7/2019