Voices for Children of NC Florida
Request for Assistance
Normalcy Funds - 5 to 17 years Old

Please Print

Date: _____ Amount Requested? _____ Full or Partial Payment: _____ Case No: _____

County: _____

Activity/Service Requested:_____

What does this include? _____

GAL Name: _____ Phone #: _____ Email: _____

Make check payable to: _____

Name and address check should be mailed to:

_____

Have alternate funding sources been researched? Yes ☐ No ☐ If yes, what are they?

_____

First name ONLY, age (Must be 5 – 17 yrs.), sex of child(dren):

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

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

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

Is this currently an active dependency case? Yes ☐ No ☐

GALP CAM Approval Signature: _____CAM Phone #: _____

CAM Printed Name:_____

How long does this activity last? (Example: 6 weeks, once, etc.): _____

If more than once, how often does it occur? Weekly ☐ Monthly ☐ Other _____

Will additional or follow up funds be required? Yes ☐ No ☐ If yes, please explain:

_____

_____

Where does activity take place? School ☐ Church ☐ Other ☐ If other please explain:

_____

Are scholarships available for this activity? Yes ☐ No ☐

Is transportation required? Yes ☐ No ☐ If Yes, who will provide it?

Please provide name of sponsoring organization of activity, address and phone # of contact person if different from above:

_____

_____

Please Note: Checks are made to the provider of the activity or service, NOT to GALs or caregivers. Please do NOT make purchases prior to approval and then request reimbursement unless Kathleen Cossey (Normalcy Committee Chair) authorizes in advance. Voices for Children has no responsibility should the child be injured or experience an illness.

Approved: _____ Denied: _____

Reason for Denial: _____

Normalcy Committee Signature(s):_____

_____

Treasurer's Use Only: Check #:_____Date Issued: _____

Issued to: _____Mailed to GALP____ GAL_____ Service Provider_____

Date Receipts Submitted: _____

6/2020