Family-Centered Services and Supports

(FCSS) Request for Reimbursement

Select the Processing Date:

October January April Other Period (enter below)

May June July

SFY:	**Sub-Awardee:**

Reimbursement Requested Calculation for the Period of: **to**

Sub-Award Total:

Services Provided this Period for Reimbursement (Enter the dollar amount spent this period next to the service provided):

Non-Clinical In-Home Parent/Child	Transportation
Non-Clinical Parent Support Groups	Parent Advocacy
Parent Education	Social/Recreational Supports
Respite	Service Coordination
Mentoring	Structured Activities
Safety & Adaptive Equipment	Youth/Young Adult Peer Support

Other Services (not listed above)

Enter dollar amount:

List the other services provided below:

Amount of this Reimbursement Request ***(calculates based on totals entered for services above)*****:**

Accumulation to Date Total ***(any Funds Received to-date, DO NOT Include the amount of this reimbursement)***:

Remaining Sub-Award Balance:

Person Completing This Form (please print):	Title:	Date:
Phone Number:	E-Mail Address:	

Sub-Awardee Certification (Certification box requires signature of Administrative Agent or FCFC Coordinator/Director)		
I certify that the amounts recorded above represent expenditures in accordance with all articles of the Sub-Award and to the best of my knowledge, all requirements have been fulfilled.		
Signature:	**Title:**	**Date:**
Mailing Address:	**City, State, Zip:**	
Phone Number:	**E-Mail Address:**	