Family-Centered Services and Supports (FCSS)

Request for Reimbursement

SFY: _____

Select Processing Date:

☐ October ☐ January ☐ April ☐ Other Period
☐ May ☐ June ☐ July (enter below)

_____

Sub-Awardee:

Reimbursement Requested Calculation			
		Sub-Award Total	
Expenditures:	**This Period**	**Accumulation to Date (= funds requested this period + advance + reimbursements received to-date)**	**Sub-Award Balance**
Funds Requested			$0

Services Provided this Period for Reimbursment			
Please select the service(s) from the list of allowable expenses below that were provided for this period			
☐ Non-Clinical In-Home Parent/Child	☐ Respite (including camp)	☐ Transportation	☐ Service Coordination
☐ Non-Clinical Parent Support Groups	☐ Mentoring	☐ Parent Advocacy	☐ Structured Activities
☐ Parent Education	☐ Safety and Adaptive Equipment	☐ Social/Recreational Supports	☐ Youth/Young Adult Peer Support
☐ Other (Explain in the space provided below)			

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:**	