January 2018

CHILDREN'S SERVICES AUXILIARY
REIMBURSEMENT REQUEST FORM

DATE: _____ Child's Gender: - Is the child over the age of 16? -

Payable to Name: _____

Address: _____

City: _____ State: ____ Zip code: _____ Phone Number: _____

Amount requested: $_____

PURPOSE OF REQUEST:

_____

By signing this document you are aware that Children's Services Auxiliary is not associated with Children & Family Services of Ventura County and all your information is private. We will not disclose information to anyone outside of Children & Family Services of Ventura County without your written request.

SUBMITTED BY: _____

Submit Claim ONCE ONLY via any of the following:

Mail: RDS Unit
4651 Telephone Rd, Suite 300
Ventura, CA 93004

Fax: 805-654-3220

Email: hsa-cfs-resources@ventura.org

CSA Office Use only – DO NOT WRITE Below this point:

Eligible Under: ☐ ILP ☐Foster/Kingap/Relative/Guardianship/Family Maintenance (choose 1)

BUDGET NUMBER: #_____CATEGORY: _____

Verified By: _____

APPROVED BY: Check one

☐ Budget Allocation
☐ Spending Procedures

CSA Approval/Denial Signature: _____ Amount approved: $ _____Amount Denied: $_____

Reason for Denial: _____