January 2019

CHILDREN'S SERVICES AUXILIARY

REIMBURSEMENT REQUEST FORM

DATE: _____ Child's Name (First Name Only): _____ Age: _____

Payable to Name: _____

Mailing Address: _____

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

Amount requested: $_____

PURPOSE OF REQUEST: _____

_____

By signing this document, you are aware that Children's Services Auxiliary (CSA) is not associated with Children & Family Services (CFS) of Ventura County. CSA, which in this situation includes our accounting firm, will have access to the information provided on this form. We will not disclose information to anyone outside of CFS, CSA and our accounting firm without your written consent.

SUBMITTED BY: _____

Submit Claim ONCE ONLY via any of the following:

Mail: Foster VC Kids
4651 Telephone Rd, Suite 300
Ventura, CA 93004
(805) 654-3220

or Email: hsa-cfs-resources@ventura.org

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

Eligible (choose 1): ☐ ILP or ☐ Auxiliary

BUDGET NUMBER: #_____CATEGORY: _____

Verified By: _____

CSA Approval (Initials): _____Amount: $ _____

CSA Denial (Initials): _____ Amount: $_____

Comments: _____

_____