120 Mountain Avenue
Suite 212
Bloomfield, CT 06002
Telephone (860) 243-1806
Fax (860) 243-0100

Children's Enrichment Funds Request Form **fax to: 860-243-0100**

PLEASE PRINT CLEARLY. INCOMPLETE FORMS CANNOT BE PROCESSED

Social Worker: ___________________________________ Date of Request: ___________
Agency/City: ____

Phone: ____________________ Cell: _________________Email:________________________

Client Name: ____

Residence City: ____ Zip: ___________

Family Ethnicity: mark all that apply (for reporting purposes only)

African___ European___ Latino___ Asian___ Other________

Number of children in client's family: ________

Make check payable to: (We *never* write check to client!)

____

Check Delivery: (circle one) **pick up** **mail***

*Mail check to: Number, Street, Apt#:
____

City: _______________________________ Zip: _____________

Amount Requested ___________________

Purpose of Request	
Mandated by Court	
Reunification	
Family Support	
Independent Living	
Family Preservation	
Relative/Foster Care	
Other	

Please describe specifically what you are requesting and why (use more paper if needed):

SW Signature: ____Date:________________

SW Supervisor's Signature: ______________________________________Date:_________