



## Financial Assistance Request Form

Applicant Information (please write legibly)

Name of child: \_\_\_\_\_ Date: \_\_\_\_\_

Address of child: \_\_\_\_\_  
(street) (city) (state) (zip)

Home #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Date of Birth of child: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_

Service/Good	Agency/Provider	# of Months	Amount Requested	Amount Approved <i>Official Use Only</i>
<b>TOTAL</b>				

Please note that all request **must** be for services and/or goods listed on the IFSP. Please note that AADD reviews GA State Policies for Family Support services quarterly and eligibility for expenses will be determined per the most recent policy, which may result in previously approved services and goods, no longer being eligible for reimbursement. In signing below I am validating the need for the above service/good and that there is no other funding sources available to meet the above listed need.

Participant/Guardian/AADD Staff: \_\_\_\_\_  
(signature) (date)

### For AADD Office Use Only

Request Date: \_\_\_\_\_ Invoice Number: \_\_\_\_\_ Invoice Date: \_\_\_\_\_

Payable to: \_\_\_\_\_

Total Invoice Amount: \_\_\_\_\_ Invoice Amount To Be Paid: \_\_\_\_\_

Comments:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Requested By	Date
AADD Account Signature	Date
Supervisor Signature	Date

**FOR ACCOUNTING USE ONLY**  
 Check Number: \_\_\_\_\_