

Solano County Resource Family Association (SCRFA)

Flex Funds Activities Reimbursement Request

Name of Resource Parent			
Address			
Phone Numbers	Cell:	Email:	

Activity Description

Activity			
Name of Organization		Activity Cost	
Address		Solano County Social Worker	
Phone Number	Cell:	Email:	
Receipt Attached	<input type="checkbox"/> Yes <input type="checkbox"/> No (explanation)		
Payment Preference:	<input type="checkbox"/> Check by Mail <input type="checkbox"/> Zelle (Please provide the phone# or email associated with your account)		

Forms MUST be submitted no later than 15 days after purchase (date on receipt)

Name of Child	Age	Foster	Adopt	Guard	Birth	Activity
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Reason for Activity	
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Reimbursement Rate: \$350.00 per Solano County Dependent per year (7/1/2024-6/30/2025)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT, INCLUDING THAT I HAVE PURCHASED THE ACTIVITIES/ITEMS IDENTIFIED ABOVE.			
Resource Parent Signature		Date	

FOR INTERNAL USE ONLY

SCRFA Reimbursement Request Form received: Date: _____

Received by: Mail Email Drop Off

Does the activity/items purchased support the development of the youth's strengths and/or enrichment?

____ Yes _____ No

Total amount remaining (\$350 max per year) as of this request: _____

Approved _____ Amount \$ _____ Denied _____ Reason: _____ _____	Date	
Program Coordinator's Signature		Date