



The Friends of Foster Children (fka Foster Care Council) is a private, nonprofit, 501(c)3 corporation, Independent of the Department of Children and Families

### REQUEST FOR FUNDS FOR CHILDREN IN FOSTER CARE

The primary goal of the **Friends of Foster Children** (fka Foster Care Council of Southwest Florida) is to enrich the lives of children in foster care by providing funds for needs and activities that increase a child's confidence, talents and self esteem. These may include, but are not limited to: art, music, dance, athletics, sporting equipment, clothing, educational materials, emergency assistance/supplies and activities such as class trips, graduation events and summer camp. **We do not accept applications for reimbursement of expenditures. Only children under DCF supervision may qualify.**

**ALL information on this application will remain CONFIDENTIAL.**

DATE \_\_\_\_\_

CHILD'S FULL NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(m/day/year)

FOSTER PARENT'S NAME \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ALL APPLICATIONS MUST MEET WITH THE APPROVAL OF THE CARETAKER.**

Has approval been obtained? Yes \_\_\_ No \_\_\_ If not, please explain \_\_\_\_\_

**Who initiated this request?** CN \_\_\_ FP \_\_\_ LS \_\_\_ RCC \_\_\_ GAL \_\_\_ DCF \_\_\_ CFCRB \_\_\_ OTHER \_\_\_\_\_

\*\*NAME OF GAL or "Other" \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Home Phone for GAL ( ) \_\_\_\_\_

I am requesting funding for the above named child for the following purpose: (give details)

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**Appropriate documentation** for all requests involving lessons is **attached**.

If request is an **ongoing** activity, how long will the funding be needed? \_\_\_\_\_

Is there a **deadline** or time frame by which funds are required? \_\_\_\_\_

In what way, do you feel, approval of this request will enrich the life of this child?

Mental Health \_\_\_\_\_ Physical \_\_\_\_\_ Educational \_\_\_\_\_ Psychological \_\_\_\_\_ Social \_\_\_\_\_ Spiritual \_\_\_\_\_

Other \_\_\_\_\_

THIS REQUEST IS FOR \$ \_\_\_\_\_ The check should be MADE TO the following PROVIDER (if applicable).

NAME \_\_\_\_\_ Phone ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**DCF/CMO CASE MANAGER INFORMATION** (\*\*GAL or "OTHER" must include this information)

Case Manager (print name) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Email \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

County \_\_\_\_\_

**Fax or Mail Request to:**

**5051 Castello Dr., #21 Naples, FL 34103 Phone: 239-262-1808 Fax: 239-262-4457**