



Medically Fragile Children’s Foundation of Northern California Disbursement Request **Form B**

If you know of a program or group servicing Medi-Cal funded, technology dependent children in/near Santa Clara County, CA that you believe could benefit from our services, please fill out the form below. All requests are subject to board review for approval and will be presented to the board at the next board meeting.

Requestor’s Name: _____ Date: _____

Requestor’s E-mail: _____ Phone #: _____

Relationship to Group or Program: _____

Group or Program Name: _____

Services Provided by Group or Program: _____

Location of services: _____ California

City

State

Ages serviced by Group or Program: _____

Diagnosis/Technologies: _____

Full amount being requested: \$ _____

Below please describe the service you would like MFCFNC to provide for this beneficiary and how it relates to our mission statement.

Check to be made out to whom: _____

Please attach or send any additional information that you would like the board to consider while reviewing your request. All forms may be e-mailed to info@mfcfnc.org or may be faxed to (408)916-4900.

FOR MFCFNC USE ONLY

Disbursement Approved Yes No

Total Disbursement: \$ _____ Check # _____ Date: / / Made out to: _____

I hereby certify or affirm the following expenses are (were) allotted in accordance with and fulfills the mission of the Medically Fragile Children’s Foundation of Northern California.

A minimum of two signatures required.

Signed,

_____ President _____ Vice President

_____ Secretary _____ Treasurer