

Logan County Intersystem Services Funding Agreement

Child's Name: _____ **Agreement Start Date:** _____ **End Date:** _____

DOB: _____ CFT Facilitator Name & Agency: _____

Informal CFT
 Formal CFT

SERVICES COVERED UNDER THIS AGREEMENT:

<input type="checkbox"/> Traditional Foster Care <input type="checkbox"/> Treatment Foster Care <input type="checkbox"/> Residential/Group Home	<input type="checkbox"/> Respite <input type="checkbox"/> Transportation <input type="checkbox"/> Other: _____
---	--

Individual to receive Services: _____

Provider Agency Name: _____

Address: _____

Phone Number: _____

AGENCY AGREEMENT:

The following agencies have agreed to fund the above stated services for the above named child. Their signature attests to the agreement of the designated agency staff to contribute the following amount:

Agency Information <small>(Name, Contact Person, Address, Phone)</small>	Agreement			Signature	Date
	Rate	# of Units	Total for this Contract		
				X	
				X	
				X	
				X	
				X	

Total:

FISCAL AGENCY: _____ **CONTACT PERSON:** _____

Address: _____ Phone Number: _____

By signing as fiscal agent of this shared funding agreement, said agency agrees to contract and pay the provider and bill those participating in this agreement for reimbursement.

Fiscal Agency Signature: _____ **Date:** _____