**EPIC SUPPORTIVE SERVICE FORM**

Week Start Date: Week Ending Date:

Participant Name SSN +4

Address City Zip Code

***Transportation Assistance***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Day | M | T | W | Th | F | Sat | Sun |
| # of round trip miles |  |  |  |  |  |  |  |
| Reimbursement amount |  |  |  |  |  |  |  |
| Bus tokens/CTA passes  |  |  |  |  |  |  |  |

Payable to: [ ]  Client

 [ ]  Other (list below)

***Child Care Assistance***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Day | M | T | W | Th | F | Sat | Sun |
| # of children |  |  |  |  |  |  |  |
| Daily hours |  |  |  |  |  |  |  |
| Reimbursement amount |  |  |  |  |  |  |  |

Payable to: [ ]  Client

 [ ]  Other (list below)

***Other Costs*** *(work clothes, tools, supplies, or other items required for youth to participate in the program)*

|  |  |
| --- | --- |
| Specify Below ( Attach itemized bills/receipts) | Cost |
|  |  |
|  |  |
|  |  |

Payable to: [ ]  Client

 [ ]  Other (list below)

It is hereby certified that the services presented in this statement were provided and all is shown correctly.

 Participant Signature and Date EPIC Agency Staff Signature and Date