

# Health Care Funds for Families Application Form



Early Learning Staff: Please refer to the [Health Care Funds for Families Procedure](#) for guidance in completing this form.

Child ID: \_\_\_\_\_ DOB: \_\_\_\_\_

Person requesting funds: \_\_\_\_\_ Phone: \_\_\_\_\_

Site/Center name: \_\_\_\_\_ Request date: \_\_\_\_\_

Provider's name: \_\_\_\_\_

Provider's phone: \_\_\_\_\_ Provider's fax: \_\_\_\_\_

Provider's address, city, zip code: \_\_\_\_\_

Date of appointment: \_\_\_\_\_

Services needed: \_\_\_\_\_

Other funding sources attempted/denied: \_\_\_\_\_

Cost of services (use estimate if necessary): \_\_\_\_\_

**Submit to:**

PSESD Early Learning ATTN: Health/Nutrition Services  
800 Oakesdale Ave. SW, Renton, WA 98057

Approved by (signature): \_\_\_\_\_ Approval date: \_\_\_\_\_

