Relapse Fund
Program Request Form

$2,500: ***Relapse Fund***
Each qualifying family if approved will receive up to $2,500.

☐ $2,500 Relapse Fund

Total Amount Requested: ***$2,500*** **/ Social Worker Signature: _____ Date: _____**

TBCF Office Use ONLY

Program Applied For	Amount Granted	Date Granted	Program Director (Initials)
Relapse Fund			

Family Approval Information

Name of Patient: _____

Name of Guardian(s): _____

Mailing Address: _____

Family Number: _____

Completed Application Received (date): _____ Effective Date: _____

1st Payment Date: _____ 2nd Payment Date: _____ 3rd Payment Date: _____

Date of Initial DFA Approval (1st Round of Support): _____

Program Director (Signature): _____ Date: _____

Executive Director (Signature): _____ Date: _____