

State of Illinois
Department of Children and Family Services
NORMAN CASH ASSISTANCE OR HOUSING ADVOCACY REFERRAL
TYPE OF SERVICE REQUESTED

Norman Cash Assistance Norman Housing Advocacy Other: _____

CLIENT INFORMATION

Family Name: _____ CYCIS #: _____

HOUSEHOLD COMPOSITION

Head of Household Name: _____ Birth Date: _____

Head of Household Name: _____ Birth Date: _____

Address: _____ Phone: (____) _____

Email Address: _____ Region: _____ Site: _____ Field: _____

Child's Name	Child Resides With	Birth Date	Relation to Head of Household	Expected Return Home Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Household Income Sources: _____ Amount: _____

Describe the crisis this request will address: _____

What led to the crisis? _____

CASEWORKER INFORMATION

Caseworker: _____ Worker ID#: _____

Agency: _____ Phone: (____) _____

Address: _____ Extension: _____

Supervisor: _____ Fax: (____) _____

Phone: (____) _____

HOUSING ADVOCACY APPROVALS

POS Supervisor Signature: _____ Date: _____

POS Housing Advocacy Program referrals must be approved by the POS Norman Liaison in the box below

SIGNATURES AUTHORIZING HOUSING ADVOCACY SERVICES

Choose One Box: Assist Client Obtain New Housing Stabilize Family in Current Housing

DCFS Supervisor _____ Date: _____

DCFS Norman Liaison _____ Date: _____

REQUEST FOR CASH ASSISTANCE

Note: Page one and two are required for cash assistance requests.

Family Name: _____ CYCIS #: _____

What will prevent the problem from occurring again? _____

Other resources explored before requesting this assistance: _____

CASH ASSISTANCE REQUESTED

1. Payee: _____ Amount: _____
 Purpose: _____ Account #: _____
 Address: _____ Phone:(____) _____
 Picked Up Mailed to: _____

2. Payee: _____ Amount: _____
 Purpose: _____ Account #: _____
 Address: _____ Phone:(____) _____
 Picked Up Mailed to: _____

3. Payee: _____ Amount: _____
 Purpose: _____ Account #: _____
 Address: _____ Phone:(____) _____
 Picked Up Mailed to: _____

4. Payee: _____ Amount: _____
 Purpose: _____ Account #: _____
 Address: _____ Phone:(____) _____
 Picked Up Mailed to: _____

SIGNATURES OF PERSONS REQUESTING CASH ASSISTANCE

Case Worker: _____ Date: _____

Supervisor: _____ Date: _____

Signature of person who will pick up the check(s): _____

Sign again after the check(s) is received from the provider: _____

SIGNATURES AUTHORIZING CASH ASSISTANCE

1. Payee: _____ Amount: _____

2. Payee: _____ Amount: _____

3. Payee: _____ Amount: _____

4. Payee: _____ Amount: _____

DCFS Supervisor: _____ Date: _____

DCFS Norman Liaison: _____ Date: _____

Norman Coordinator: _____ Date: _____