Legal Communication Access Fund (LCAF)

Reimbursement Request Form

The Legal Communication Access Fund (CAF) provides for the reimbursement of reasonable costs incurred in the provision of access to effective communication.

***Requestor's Name:** _____

***Organization Name:** _____

***Email:** _____

***Address:** _____

***City:** _____ ***State:** _____ ***Zip Code:**_____

***County:** _____

***Phone number:** _____

***Amount of Reimbursement Request: $**_____ (must submit Itemized Cost Worksheet)

***Date(s) of Service:** _____

***Begin Time of Auxiliary Service:** _____AM / PM

***End Time of Auxiliary Service:** _____AM / PM

***Number of Individuals Served:** _____

***Type of Auxiliary Service or Aid Used:** _____

_____

_____

***Name of Contracted Licensed Sign Language Interpreter (if used):**

_____

Required fields

Certification

I/we certify, under penalty of perjury under the laws of the United States of America, that all information provided on this form are true, accurate and complete. I/we also acknowledge that any deliberate omission, misrepresentation, or falsification of any information contained on this form may be punishable by criminal, civil, or administrative penalties, including but not limited to the imposition of fines, civil damages, and/or imprisonment.

_____

Printed Name and Title

_____

Name of Company/Organization

_____ _____

Signature Date

FOR NCDHH STAFF USE ONLY

Date Received:	Received by:
W-9 Received: ☐ Yes ☐ No	AB # assigned:
Itemized Worksheet Received: ☐ Yes ☐ No	Date Posted: