

Rural Communication Access Fund (RCAF) Reimbursement Request Form



The Rural Communication Access Fund (RCAF) provides for the reimbursement of reasonable costs incurred for the provision of access to effective communication to rural areas of the state.

*Requestor's Name: _____

*Organization Name: _____

*Email: _____

*Address: _____

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

*County: _____

*Phone number: _____

*Dollar Amount of Reimbursement Request: \$ _____ (must submit itemized cost worksheet)

*Date(s) of Service: _____

*Begin Time of Service: _____ AM / PM

*End Time of Service: _____ AM / PM

*Number of Individuals Served: _____

*Type of Service Used: _____

*Name of Contracted Licensed Sign Language Interpreter or Video Remote Interpreting Service:

***Required fields**

***Type of Situation or Assignment** - Please specify details in the field listed below

- Medical
 - Hospital / Emergency Department
 - Clinic Visit
- Dental
- Mental Health
- Employment Related
- Community Event
- Presentation / Training
- Other

***Details of Assignment:**

****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

***Required**

FOR NCDHH STAFF USE ONLY

Date Received:	Received by:
W-9 Received: <input type="checkbox"/> Yes <input type="checkbox"/> No	AB # assigned:
Itemized Worksheet Received: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Posted: