**Evidence Based Programs (EBPs) Reimbursement Form**

### Instructions: Please ensure that all applicable parts of this form are completed legibly and in their entirety. If you have questions regarding this form, please contact your local Community Based Care (CBC) lead agency.

This form is intended for Community Based Care (CBC) Lead Agencies who have installed an EBP within their community. The reimbursement of the expenses will assist CBCs in enhancing their local array of preventive services to better serve families in their home, preventing the need for foster care placement. The preventive services must be rated and approved by the federal Title IV-E Prevention Services Clearinghouse and are identified in Florida’s five-year title IV-E prevention program plan.

This form must be completed by the designated representative of the CBC. Please enter the expense of each applicable item and provide supporting documentation.

**Section I: General Information**

Name of designated representative:

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Name of CBC Lead Agency:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell number of designated representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address:

Name of EBP installed:

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|  |  |  |  |
| --- | --- | --- | --- |
| **Reimbursement request** | | | |
|  | Date of expense | Total Cost of item | Amount of reimbursement request |
| Training (Initial and ongoing) |  |  |  |
| Curriculum and Materials (Initial and ongoing) |  |  |  |
| Certification |  |  |  |
| Fidelity Monitoring and Evaluation |  |  |  |
| Technical Assistance |  |  |  |
| Staff Salary: Name and Role *(Example – John Smith, Supervisor, Masters Clinician)* |  |  |  |
| Staff Salary: Name and Role |  |  |  |
| Staff Salary: Name and Role |  |  |  |
| Staff Salary: Name and Role |  |  |  |
| Staff Salary: Name and Role |  |  |  |
| Staff Salary: Name and Role |  |  |  |
| Other Start-Up Costs: List Item*(Example - developing office space)* |  |  |  |
| Other Start-Up Costs: List item |  |  |  |
| Other Start-Up Costs: List item |  |  |  |
| Other Start-Up Costs: List item |  |  |  |
| Other Start-Up Costs: List item |  |  |  |
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|  |  |  |  |
|  |  |  |  |
| **Total** |  |  |  |

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***Supporting Documents should include but not limited to receipts of expenses, contracts with vendor(s) completing the EBP training to the CBC, contracts/working agreements with providers trained to deliver the EBP services, copies of EBP training certifications for each provider trained to deliver the selected EBP(s), and picture of items remodeled/fixed to comply with EBP service delivery requirements.***