

RECEIPT FORM FOR RESOURCE DISTRIBUTION PROGRAM
HELP FAST

FOR OFFICE USE ONLY

Please Print

Head of HH Name: _____

Head of HH SSN #: _____

Participant Name: _____

Number In HH: _____ County: _____

<u>List Services Provided</u>	<u>Amount</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____

TOTAL: \$

Comments: _____

I certify I have received the services listed above

Participant Signature: _____

Date: _____

CMCA PROVIDES SERVICES ON A NON-DISCRIMINATORY BASIS

Input #: _____

Date: _____

F101 Help Fast Revised 10/2/09-Buff

CSBG ELIGIBLE: YES, Under 200% NO

	<u># OF UNITS</u>	<u>VALUE OF SERVICE</u>
1. Maximum amount eligible for billing (Units = # in HH x \$60.00)	_____	\$ _____
2. Amount previously billed	_____	\$ _____
3. Amount of service provided this time		\$ _____
4. Amount of carryover assistance from previous service	_____ +	\$ _____
5. Value of billable service this time		\$ _____
6. Units to bill this time X \$60.00 =		\$ _____
Units: \$60=1; \$120=2; \$180=3; \$240=4; \$300=5		
7. Carryover amount (#5 - #6)		\$ _____
8. Number of units eligible for future billing	$\#1 - (\#2 + \#6)$ _____ - (_____ + _____)	= _____ Units

Check source(s) of support for service(s) provided:

- | | |
|---------------------------|---------------------------|
| _____ CMCA Emergency Fund | _____ FEMA |
| _____ Love Tree Program | _____ Dollar More Program |
| _____ Local County Funds | _____ Housing Trust Funds |
| _____ Other _____ | |

Staff Signature: _____

Entered by: _____ ARRA