

CASE NAME: CONFIDENTIAL (Mother's Name) Case#: CONFIDENTIAL (JV# or CWS/CMS Case# if in ER)

PERSON(S) SERVED: [REDACTED]

[REDACTED]

[REDACTED]

FUNDING SOURCE: ☐ CWS ☐ CSEC ☐ ILP ☐ PSSF ☒ ItJ Wraparound

DESCRIPTION: After care Services with Evolve Yout h Services

Fiscal Key & Authorization#	AUTHORIZATION	DETAIL
	Start date - End date	March 2022 thru June 2022
	Frequency	Monthly
	Unit cost	\$8,500.00
	Estimated Total Cost	\$34,000.00

PAYEE: Evolve Youth Services [W-9](#) C1 On file or MIA ☐ Attached
 PROVIDER NAME: Evolve Youth Services PHONE: _____
 PAYEE ADDRESS: 685 F St Arcata, CA 95521

Kim Costa 07/19/2022

MANAGER SIGNATURE REQUESTING _____ DATE _____

Amber Davis (Jul 19, 20n 16:03 PDT) 07/19/2022

DEPUTY DIRECTOR SIGNATURE -ligl APPROVED DATE


Crystal M. Mytan (Jul 19, 2022 20:29 PDT)

DIRECTOR SIGNATURE APPROVED _____ DATE _____

- FISCAL USE ONLY -		
Date Paid	Vendor	Amount