

**State of Connecticut  
Department of Children and Families**

**EXTRAORDINARY EXPENSES  
TO FACILITATE AND SUPPORT A PLACEMENT**

Child's Name	Link Number
--------------	-------------

**Item, adaptation, services or equipment required** (attach the DCF-2102, "Discharge Plan for a Child with Complex Medical Needs," if applicable): \_\_\_\_\_

---

---

---

---

---

---

---

---

**Attempts to secure other sources of funding** (explain):

---

---

---

---

---

---

---

---

**Expenses** (indicate name of company or service provider, contact person, date of contact, quoted price, estimated time frame for delivery or completion of required work):

Company/Service Provider	Contact Person	Date of Contact	Price	Time Frame

Social Worker	Date
Social Work Supervisor	Date
Program Manager	Date