COUNTY_____
COUNTY NUMBER _____

AUTHORIZATION FOR FUNDS ACCESS
LINKS PROGRAM

I hereby certify that the following individuals meet the eligibility criteria to receive funding through the designated LINKS special funds, in accordance with the information outlined on the reverse of this form.

_____
Social Work Supervisor, Date of signature

Name	DOB	SIS ID#	LINKS FUNDING SOURCE ELIGIBILITY			
			Scholarship	Trust Fund Aftercare	Transitional Housing	Extremely High Risk Youth

NE- Individual is not and will not be eligible for the funds indicated
X - Individual is eligible to be authorized for the funds indicated
* - Individual is already authorized for these funds