



**Interagency Notification
Individual Career Advancement Network (ICAN)**

_____ XXX-XX-_____
Participant Name *Town of Residence* *Social Security Number*

ICAN Component:

- Supervised Job Search
 Job Search Training
 Self-Employment Training
 Education
 Job Retention
 Workforce Innovation and Opportunity Act (WIOA)

Participant Reimbursements:

Date:	Type: <i>(Transportation, Childcare, Other)</i>	Items being Purchased:	Amount:
<input type="checkbox"/> Customer <input type="checkbox"/> Vendor	Vendor Name and Address:		
Date:	Type: <i>(Transportation, Childcare, Other)</i>	Items being Purchased:	Amount:
<input type="checkbox"/> Customer <input type="checkbox"/> Vendor	Vendor Name and Address:		
Date:	Type: <i>(Transportation, Childcare, Other)</i>	Items being Purchased:	Amount:
<input type="checkbox"/> Customer <input type="checkbox"/> Vendor	Vendor Name and Address:		

*Customer payments: Payment is issued directly to the customer to their EBT card or by check
 Vendor: Payment is issued to the person/business providing the product or service.*

ICAN participant reimbursements must be reasonable, necessary, and allowable for ICAN participation. Please see the current ICAN spending guidelines for expense allowability and verification suggestions. By signing this form, I am indicating that the expense(s) is reasonable, necessary and allowable and also that the need for reimbursement and verification are noted in the participant's file

Agency Name and Name of Individual Completing This Form: _____

Signature: _____ **Date:** _____

Return form to ESD at: *AHS.DCFESDICAN@vermont.gov*