

**REQUEST FOR AUTHORIZATION  
of  
EQUIPMENT PURCHASE**

The following information must be sent to the Missouri Department of Health and Senior Services, Community Food and Nutrition Assistance, P.O. Box 570, Jefferson City, MO 65102 at least 45 days before purchase/requisition.

This form shall be completed before the purchase of equipment exceeding the cost of \$500.00.

I hereby request permission to purchase the following item from CSFP Program funds:

Item \_\_\_\_\_ Quoted Price \_\_\_\_\_ Vendor \_\_\_\_\_

Description \_\_\_\_\_

Funding source to be used:

\_\_\_\_ Purchase can be paid for out of the currently available CSFP funds within the agency, i.e. current budget.

\_\_\_\_ The purchase will require an increase of \$ \_\_\_\_\_ in the amount of administrative funds available.

Justification:

\_\_\_\_ Required for startup of operation.

\_\_\_\_ Required for the operation of an additional site.

\_\_\_\_ Required for use by additional program staff personnel.

\_\_\_\_ Equipment currently available must be surplusd

I.D. Number \_\_\_\_\_ Condition \_\_\_\_\_

Provide narrative justification:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on reverse)

Basis for purchase:

\_\_\_\_ The item is to be used solely for the CSFP Program.

\_\_\_\_ Item purchase price is to be shared with \_\_\_\_\_ Program. Charge to each program is pro-rated on intended use.

Requested by \_\_\_\_\_

Name

Agency

Date

Approved by \_\_\_\_\_ Date \_\_\_\_\_

Name and Title