



# Funding Verification Form

**EVENT #:** 8698

**TITLE:** Employee Dental Benefits

**TOTAL FUNDING AMOUNT:**

|            |
|------------|
| AMOUNT     |
| \$ No COST |

**FUNDING SOURCE:**

| BUDGET YEAR | FUND | DEPARTMENT | ACCOUNT | ACTIVITY |
|-------------|------|------------|---------|----------|
| 2021-2022   |      |            |         |          |

**NOTES**

Fiscal Impact Statement: There is no fiscal impact.