DEPARTMENT OF MENTAL HEALTH

SPECIAL SERVICES FUNDING REQUEST

Check one: [ ] Children's Services
[ ] Adult Services (CRT client)
[ ] Adult Services (non-CRT client)

Client's Name (full) _____

Date of Birth _____ Social Security Number _____

Agency _____

Diagnosis: DSM-IV-TR Code _____
Diagnosis (spell out) _____

Financial Status: [ ] No benefits [ ] SSI [ ] SSDI
[ ] General Assist. [ ] Medicaid [ ] Medicare
[ ] Other (specify) _____
[ ] Applying for benefits (specify) _____

Brief description of client: _____
_____
_____
_____

Brief description of need: _____
_____
_____
_____

Specific Request: $ _____
For _____

[ ] One time cost [ ]Ongoing need (if ongoing, how will it be funded
In the future?) _____

****

Name _____
(type or print)

Signature _____ Date _____
(CRT or Children's Services Coordinator)

SPECIAL SERVICES FUNDING AUTHORIZATION

I N V 0 I C E

Check one: [ ] Children's Services
[ ] Adult Services (CRT client)
[ ] Adult Services (non-CRT client)

In accordance with the approved Individual Plan of Care,
_____ requests payment for the
(agency name)
following services necessary to support _____
in the community. (client initials)

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Services	Start Date	End Date	Cost
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
		TOTAL COST:	$ ==========

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AGENCY CERTIFICATION

I certify to the best of my knowledge and belief that these services are necessary and an extraordinary expense not covered by reimbursement through any other grant or contract.

Name of Authorized Certifying Official _____
(type or print)

Title of Authorized Certifying Official _____
(type or print)

Signature _____ **Date** _____

Telephone _____

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(This space for DMH Use)

Total Payment Amount Approved $ _____

Authorized by _____ _____
(signature) (date)

_____

(title)