COMMUNITY REHABILITATION & TREATMENT SERVICES (CRT)
SPECIAL SERVICES FUNDING REQUEST

Special Services Funding is requested for needs and/or services necessary and supporting the approved Individual Plan of Care (IPC) for the following **enrolled CRT client**.

Client Name (full): _____

Date of Birth _____ Social Security Number _____

Agency _____

Diagnosis: DSM-IV Code _____ Diagnosis _____

Financial Status: ❑ No benefits ❑ SSI ❑ SSDI ❑ General Assistance
❑ Medicaid ❑ Medicare ❑ Other Insurance
❑ Other (specify) _____
❑ Applied for benefits (specify) _____ When? _____

Brief description of client: _____
_____
_____
_____

Brief description of need and how it supports IPC: _____
_____
_____
_____

Describe resources already explored: _____
_____
_____

Specific Request: $_____ For _____
❑ One-time cost ❑ Ongoing need (if ongoing, how will it be funded in the future?)
_____

Has client received special funds previously? _____ If yes, when?_____

Name of person to contact with questions regarding this form: _____

Phone Number: _____

CRT Director's Name: _____
(*Type or Print*)

CRT Director's Signature: _____ Date: _____

CRT SPECIAL SERVICES FUNDING AUTHORIZATION/
INVOICE FORM (OTHER THAN DENTAL CARE)

Designated Agency _____

Client Initials _____

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

DESIGNATED AGENCY CERTIFICATION

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

Name of person to contact with questions regarding this form: _____

Phone Number: _____

Name of CRT Director: _____
(*Type or Print*)

Signature: _____ Date: _____

Phone Number: _____

THIS SPACE FOR DEPARTMENT OF MENTAL HEALTH AUTHORIZATION

Total payment Amount Approved: $_____

Authorized by: _____ Date: _____
(Signature)

_____
(Title)