

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

INVOICE

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)

Table with 4 columns: Services, Start Date, End Date, Cost. Includes a TOTAL COST row at the bottom.

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 _____

(This space for DMH Use)

Total Payment Amount Approved \$ _____

Authorized by _____ (signature) _____ (date)

(title)