APPENDIX C

EFT/Waiver and Individualized Service Budget Signature Sheet – Initial and Renewal

Child Name:_____Date of birth:_____
Date submitted:_____Date determined eligible:_____Budget period:_____to:_____
Submitting Agency:_____
Address:_____

_____
MSR#:_____SS#/Medicaid #:_____
DA/SSA#:_____DCF# _____

	Office or Print name	**Signature**	**Date**:
DCF	District Office:		
	District Director:		
	Placement Coordinator:		
DA/SSA	DA/SSA:		
	Case Manager:		
	Children's Director:		
	Business Manager:		
Other	Name of Agency:		
	Authorized signature		
Family If not present On treatment plan	Parent(s)/guardian(s):		
	Client (if appropriate)		

DMH Authorization by:

_____Clinical Care Coordinator
Name

_____
Signature

_____
Date

Technical Reviewer initials:_____Date:_____

Procedure code:_____

Daily rate:_____
DMH or DCF:_____

Effective date:_____
Expiration date:_____
Comments:_____
_____
_____