VT DEPARTMENT OF MENTAL HEALTH
SPECIAL SERVICES FUNDING AUTHORIZATION INVOICE
For Child, Adolescent and Family Services

Client's Name (Legal Name): _____

Date of Birth: _____ Medicaid Number: _____

Agency: _____

Diagnosis: DSM 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:

Dollar Amount of Request: _____ ☐ Check if this Request is for End of Year Pooled Funds

Request: _____

Case Manager: _____

Case Manager's Signature: _____ Date: _____

Case Manager's email address (required): _____

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In accordance with the approved Individual Plan of Care, _____ requests
(Agency Name)

payment for the following services necessary to support _____ in the community.
(Client Initials)

Services:	Start Date	End Date	Cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Type of Funds: ***Total Cost:*** _____

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: _____

Title of Authorized Certifying Official: _____

Signature of Certifying Official: _____

Telephone #: _____ Email address (required): _____

This space for DMH use only.

Total Payment Amount Approved: _____

Authorized by: _____

Title of Authorized Signer: _____

Funding: DA Amount: _____ DMH Amount: _____

DMH Business Office Authorized Signature:

_____

Comments: