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	Socia	al Security Number	r
Agency			
Diagnosis: DSM	-IV Code	Diagnosis	
Financial Status:	☐ Medicaid☐ Other (specify)	☐ Medicare	☐ SSDI ☐ General Assistance ☐ Other Insurance
	☐ Applied for be	enefits (specify)	When?
Brief description	of client:		
Describe resource	s already explored: _		
Specific Request:	\$F ne cost	For ng need (if ongoing	g, how will it be funded in the future?)
Has client receive	d special funds previo	ously? If	yes, when?
Name of person to	contact with questio	ns regarding this fo	orm:
-			
CKI Director 8 N	ame:	(Type or Print)	
CRT Director's S	gnature:	(-), (-), (-), (-), (-), (-), (-), (-),	Date: