REQUEST FOR USE OF HCBS FUNDING

Case Management organization submitting request:
Case Manager name:
Date Submitted:

Participant name:
Date of birth:
Social Security number:
Medicaid number:

Filling vacant HCBS funding
Additional HCBS funding

Child Adult If Child, will School District/Auxiliary Placement pay match/tuition? School district name?		Yes No
HCBS anticipated start date:	Current service funding source if applicable:	Urgent (explain below) Non-urgent
Community Support Provider:		

SSI: **Indicate SSI status for eligibility/LOC purposes.**

Status	Currently receiving	Never applied	Application pending	Denied

Submitted by:	Date:

Describe need of request:

Residential
Day
Pre VOC
Supported Employment

Medical Equipment & Drugs
Speech, Hearing, Language
Other Medical

DDD USE ONLY		
Resource coordinator contacted ☐Yes ☐No	Resource coordinator comments included ☐Yes ☐No	
☐ Funding approved ☐ Agency advised to place on waiting list ☐ Funding not approved	☐ Pended for more information; Comments	
Program Specialist signature:		Date:
DDD Director or Designee signature:		Date:
Date faxed to agency:		Staff initials:

Urgent status is defined as:
1. Homeless or at imminent risk of being homeless.
2. Currently residing in an abusive, neglectful or exploitive situation.
3. In a life-threatening situation.