

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:

Child	Adult	If Child, will School District/Auxiliary Placement pay match/tuition?	Yes	No
School district name?				
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
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Submitted by:	Date:
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Describe need of request:

- | | |
|----------------------|---------------------------|
| Residential | Medical Equipment & Drugs |
| Day | Speech, Hearing, Language |
| Pre-Vocational | Other Medical |
| Supported Employment | |

DDD USE ONLY

Resource coordinator contacted <input type="checkbox"/> Yes <input type="checkbox"/> No	Resource coordinator comments included <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Funding approved <input type="checkbox"/> Agency advised to place on waiting list <input type="checkbox"/> Funding not approved	<input type="checkbox"/> 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.