CDDO Funds Request Form- Individual Request version

Date of Request: Click here to enter text.

INFORMATION ON PERSON FOR WHOM FUNDING IS REQUESTED:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: Click here | | First Name: Click here | | DOB: Click here |
| Address: Click here | City: Click here | | State: Click here | Zip: Click here |
| MCO: Click here | Care Coordinator: Click here | | Is the person Medicaid eligible?  Yes No | |

Guardian:

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: Click here to enter text. | | First Name: Click here | |
| Address: Click here | City: Click here | State: Click here | Zip: Click here |
| Phone: Click here to enter text. | | Email: Click here to enter text. | |

Guardian Acknowledgment of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payee:

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: Click here to enter text. | | First Name: Click here to enter text. | |
| Address: Click here | City: Click here | State: Click here | Zip: Click here |
| Phone: Click here to enter text. | | Email: Click here to enter text. | |

Targeted Case Management:

|  |  |
| --- | --- |
| Agency: Click here to enter text. | TCM Name: Click here to enter text. |
| Phone: Click here to enter text. | Email: Click here to enter text. |

Identify the category of this request and describe what is being requested

Medicaid Ineligible Case Management Payment

Personal Needs

Direct Service

Other Requests

What dollar amount is being requested/identify specifics of the cost of the item or service:

Click here to enter text.

What item/service/support is being requested? What service/support need will be met if the request is approved? Describe the expected outcome if the request is approved. How is this need addressed in the PCSP? Provide PCSP documentation. Click here to enter text.

Will this amount cover the entire need or will other financial resources be necessary? Explain:

Click here to enter text.

What other resources are available or have been pursued and either utilized or denied: (insurance, financial, donations, foundations, organizations, family, friends, etc.) Identify specifically. Demonstrate exploration/exhaustion of community resources.

Click here to enter text.

Income Sources for the Individual: Demonstrate the individual’s/family’s capacity to privately pay for the service/product requested.

House hold income (adult- own resources; for a minor must include family’s resources): Click here to enter text.

Average Monthly Income (net)

|  |  |  |  |
| --- | --- | --- | --- |
| SSI/SDI | Click here to enter text. | Food Stamps | Click here to enter text. |
| Family Subsidy/Support | Click here to enter text. | Employment | Click here to enter text. |
| General Assistance | Click here to enter text. | Alimony/Child Support Received | Click here to enter text. |
| TANF | Click here to enter text. | Trust Fund/Adoption Subsidy | Click here to enter text. |
| Other | Click here to enter text. | Total Income | Click here to enter text. |

Average Monthly Expenses

|  |  |  |  |
| --- | --- | --- | --- |
| Mortgage/Rent | Click here | Electric/Gas | Click here |
| Phone/Cable/Internet | Click here | Water/Trash | Click here |
| Food/Laundry | Click here | Clothing | Click here |
| Transportation | Click here | Child Support/Alimony Paid | Click here |
| Insurance | Click here | Child Care | Click here |
| Other (explain) | Click here | Total Expenses | Click here |

* **For Medicaid Ineligible Case Management- expenses are not needed above; resources section is to be filled out. When was the last Medicaid application submitted?** **Documentation of a denial should be attached.**
* Attachments for further documentation may be submitted with the request.
* Additional information, clarification and documentation may be requested by the CDDO and/or committee.
* Where necessary or appropriate bids from more than one provider source deemed may be requested.
* CDDO’s preference is to pay the amount directly to the provider who is recognized or certifies for the service being provided. Documentation that the service was provided will be required.
* Other follow-up may be requested as determined appropriate.

**Funds review will be completed by the Funding committee in accordance with the Local Finance Plan. State Aid funds utilization must meet I/DD Taxonomy Code requirements. The intent is for all funds to be used to benefit services for developmentally disabled individuals in Cowley County. All requests will be reviewed and considered by the CDDO to assure appropriate and fair utilization of funds available and accountability. All requests will be reviewed but may not necessarily be approved. There is no assurance or entitlement related to these funds.**

Funding Committee Determination as necessary: (date)Click here to enter text.

CDDO Action Determination: (date)Click here to enter text.

What Follow-up is expected?Click here to enter text.

Follow-up status:Click here to enter text.

CDDO Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DateClick here

Date of review and signatures of others present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_