|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name: | Date of Birth: | | |
| MaineCare/Social Security: | Gender: | | |
| Address: | | | |
| **Date of Request:** | **Total Amount Requested** | | |
| **Category of Request:**  □ Adaptive Equipment  □ Consultation/Evaluation/Therapy  □ One to One Support  □ Parent Training/Education | | □ Room and Board  □ Safety  □ Transportation  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Service Description:** | | | |
| **Youth Primary Diagnosis:**  □ Autism  □ Developmental Delays (0-5 yrs./old)  □ Intellectual Disability | | □ Medically Fragile  □ Mental Health Disability | |
| **Parent Guardian Information** | | | |
| Parent/Guardian Name: | Phone: | | |
| Parent/Guardian Responsibility Acceptance signed (in chart) □ Yes or □ No | | | |
| **Individual Requesting Funds** | | | |
| Name of Person Requesting Funds: | | | |
| Agency Name (if applicable): | | | |
| Phone: |  | | |
| Street Address: | City/Town: | | |
| State: | Zip Code: | | |
| **Vendor Information** | | | |
| Vendors Name: | | | |
| Vendor’s address: | City Town: | | |
| State: | Zip Code: | | |
| Phone: | Vendor Customer #: | | |
| Certificate of Liability in chart (if Applicable) □ Yes or □ No | | | |
| **Justification of Funding Request** | | | |
| Child’s Individual Plan (pertaining to request) | | | |
| How is this request expected to benefit the youth? | | | |
| Therapist Name and Credentials | | | |
| Therapist recommendations supporting the request as it relates to child’s diagnosis and treatment needs (kept in chart) | | | |
| **Summary of Other Funding Search** | | | |
| Parent Contribution | Comments | | |
| MaineCare Prior Authorization Amount | MaineCare Letter of Denial □ Yes or □ No | | |
| Amount #3 | Contact Name | | Date |
| Amount #4 | Contact Name | | Date |
| Amount #5 | Contact Name | | Date |