|  |  |
| --- | --- |
| 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□ TransportationOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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 |