

**POWESHIEK COUNTY
MH/DD SERVICES FUNDING REQUEST
out of county**

Date: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Social Security #: _____ **Date of Birth:** _____

This funding request should be preceded by a completed central point of coordination application to determine eligibility for county funding. If the client has not completed a cpc application recently (2 years if no changes at all) that individual should be provided the telephone number of the cpc office to make application.

Provider name: _____

Provider address: _____

(or business stamp)

Provider phone #: _____ **Provider fax #:** _____

Business office contact name/number: _____

Please check which service is requested, the level anticipated, the provider's initials, and the dates:

<i>Service</i>	<i># requested</i>	<i>unit rate</i>	<i>requested start date</i>	<i>projected end date</i>
_____ <i>outpatient therapy</i>	_____	_____	_____	_____
_____ <i>medication mgmt</i>	_____	_____	_____	_____
_____ <i>psychiatric eval</i>	_____	_____	_____	_____
_____ <i>Other --</i> _____				
_____ <i>Other --</i> _____				

If the requested start date precedes the date of the funding request, please provide a brief explanation, to allow consideration for an exception to policy. _____

Please check appropriate line, (if supporting documents are not provided, eligibility cannot be determined, and a denial will likely result):

___ **A current icp, program plan, or treatment plan is attached.**

___ **Diagnostic information is attached.**

___ **Plans and/or diagnostic information will follow within one week.**