

Request for Funds *(for vendor or basic needs purchases)*

Select the box to the left of the program in which the consumer is enrolled.

Program	Unit #	Fund #
<input type="checkbox"/> The Children's Partnership	812	098
<input type="checkbox"/> ATCMHMR - Only	854	136
<input type="checkbox"/> YAFAC- <input type="checkbox"/> CIS, or <input type="checkbox"/> SS (select one)	855	028 079

Check for Vendor purchase Petty cash Store Card Bus Pass Voucher service _____ voucher number

Check one: Enrolled Child Family Unit (includes child) Non-enrolled sibling _____ age Parent/Caregiver

Client Name: _____ Parent/Guardian Name: _____

Care Coordinator/Parent Liaison: _____

Insurance Type: Medicaid STAR Medicaid CHIP MAP Private Insurance No insurance

PURCHASE INFORMATION:

Date: _____ Description of Purchase: _____

Service Code: _____ Classification: _____ Amount requested: _____

Check pick-ups are allowed only between 2:30 and 4:30 Monday through Friday. Check one of the options below:

- Request is emergent (same day turnaround)
- Request is urgent (24 hr. turnaround)
- Request is for turnaround in 2 - 6 days

Indicate date check is needed: _____

If needed in less than 7 business days, what is the reason check is needed so quickly?

Date Care Team approved purchase: _____

Domain:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Psych/Emotional | <input type="checkbox"/> Home/A Place to Live | <input type="checkbox"/> Family/Relationships | <input type="checkbox"/> Daily Living |
| <input type="checkbox"/> Education/Voc | <input type="checkbox"/> Social/Rec. | <input type="checkbox"/> Health/Medical | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Safety/Crisis | <input type="checkbox"/> Cultural/Spiritual | |

Justification (Why are you using this purchase to meet this need?): _____

What other options have you tried? (if applicable) _____

In the future, how will this be addressed by the family? _____

VENDOR INFORMATION [IMPORTANT! WE CAN'T PROCESS REQUESTS WITHOUT NEW VENDOR NAME, ADDRESS, ID]

New Vendor

Vendor Name: _____
 Vendor ID #: _____
 Vendor Phone #: _____
 Vendor Address: _____

Current Vendor

Vendor Name: _____

Supervisor Approval: _____

Attestation Statement:
 I recognize that these funds represent funding of last resort. I have made reasonable efforts to arrange for the provision of vendor goods or financial assistance through alternative funding sources or community entities. Either there are no alternatives, or the above requests have been refused.
 Signature _____