Service Review Collaborative Funding Request

Youth Information

Last name _____ First name _____ DOB _____

Parent's Name _____ School Attending _____

Address _____ City _____ Zip _____

____ Specialized Educational Services	**Current Systems Involved**			HMG Yes____ No ____
____ Developmental Disabilities	_____ Behavioral Health	_____ Juvenile Justice	_____ Children Services	

Lead Service Coordinator _____ Phone _____

Agency Name: _____ Fax _____

Requested Service(s)

Provider Name	Service Type	Start Date	End Date	Unit	Cost per Unit	# of units requested	Total Cost
							$ -
							$ -

Parents/caregivers approve this service: Yes____ No ____ **Parental Contribution**

Youth age 18-21 approves this service: Yes ____ No ____ **Total amount of request** $ -

If service type/unit is "other" describe in detail: _____

Parent Signature: (confirming parental contribution) _____

Approving Supervisor: _____
print signature

By signing this form, I agree to provide the services listed above. I understand that I will not be reimbursed for any services provided prior to the encumbrance date on the Purchase Order nor for any services outside of the timeframe specified.

Provider Signature

Request approved _____ yes _____ no Request amended _____ yes _____ no

If request was amended please describe in detail: _____

SRC recommendations: _____

Funding Source	**Contribution**	**SRC Committee Representative Signature**
____ FCSS		
____ Home Choice		
____ MH		
____ JJ		
____ DD		
____ JFS		
____ ESC		
____ Parent		
____ YIC		
Total		

Date Lead Service Coordinator notified

Fax completed form to Fawne Fisk @ 330.491.9731

Requests received by end of business on Monday will be presented on Wednesday.