Service Review Collaborative Funding Request

Youth Information

Last name ____________ First name ____________ DOB ____________

Parent's Name ____________ School Attending ____________

Address ____________ City ____________ Zip ____________

Current Systems Involved

___ Specialized Educational Services   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		
Total		

Date Lead Service Coordinator notified

Fax completed form to Patty Kovacs @ 330.491.9731

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

revised March 2013