Family Support Services Request: (please print)

Date: _____ Requested For:_____

Making Request: _____ Phone Number: _____

Mailing Address: _____

_____Service Support Request

_____Adaptive equipment _____Special diet _____Diapers/Attends/Pull Ups/Wipes

_____Camp _____Home Modification _____Other

Description:_____

_____

_____Respite Request

_____Hourly ($5 per hour/1-9 hours) _____Daily ($50 per day/10+ hours)

Description: _____

_____Below this line for office use only_____

Review:

_____Eligible *(CHECK WITH LIST FROM JOJEAN)*

_____Prescription/Letter of necessity from physician, therapist or other professional

_____Not Limited/Excluded Expenditure. (*CHECK BROWN CB DD POLICY)*

Explain:_____

_____Funds are Available *(CHECK WITH LORI YOAKEM)*

$_____ Total Amount Requested

$ _____/_____ % FSS Obligation

$_____/_____ % Family Obligation

$_____ Amount Approved for Request

_____Improves living environment *(SHOULD BE CLEAR FROM PRESCRIPTION/LETTER OF NECESSITY)*

_____Facilitates care of individual *(SHOULD BE CLEAR FROM PRESCRIPTION/LETTER OF NECESSITY)*

Response:

$_____ Amount Approved for Request

_____Verbal _____Written _____Date Stamp _____Signature _____Email

Notes:

_____