

**TAMA COUNTY
SERVICE FUNDING REQUEST -- PLACEMENT APPROVAL**

Submit Request for Funding

Date: _____

Applicant/Consumer Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Diagnosis: _____

*Income: (source & amount) _____

*Resources (source & amount) _____

**If requesting outpatient mental health therapy or psychiatric services, do not complete

Service requested: _____

Agency to provide service: _____

Requested starting date: _____ Projected Ending Date: _____

Number of units of Service requested: _____ Cost per unit of service: _____

Circle type of unit: hour day month quarterly other-identify: _____

List Current Services & Providers and if these are expected to continue:

Is there a Case Manager assigned to this consumer? Yes No If yes, identify: _____

Person requesting service: _____ phone number: _____

Address: _____

The current ICP, Program Plan, or Treatment Plan must be attached or the funding request will be mailed back to the person requesting the service.