

**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  
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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: \_\_\_\_\_

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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.**