COUNTY SOCIAL SERVICES IHH-MCO FUNDING REQUEST FORM

Please complete this form and email your request with explanation for consideration and authorization to CSS Service Broker:

Raina Kellogg @ rkellogg@countysocialservices.org

CLIENT NAME: (FIRST M.I. LAST) _____

MEDICAID STATE ID:_____ (if known) CSN CLIENT ID: _____(if known)

CLIENT'S PRIMARY FUNDING STREAM: HAB_____ Waiver(Identify)_____

FUNDING START DATE: _____ / _____ / _____Waiver(Wait List)_____

FUNDING END DATE: _____ / _____ / _____ IS THIS A RENEWAL? ____ or NEW____

SERVICE PROVIDER NAME: _____

SERVICE PROVIDER ADDRESS (AT LEAST CITY): _____

SERVICE INFORMATION: (See County Social Services Covered Services and Rates for guidance)

- **5-DIGIT COA: (if known) _____**
- **SERVICE DESCRIPTION: _____**
- **TIER OR U-CODE (if applicable): _____**
- **SERVICE RATE (if known): _____**
- **NUMBER OF UNITS: _____ PER ☐ MONTH ☐ APPROVED PERIOD**

(CHECK ONE OF THESE TWO)

JUSTIFICATION FOR FUNDING IS NEEDED:

_____

_____

_____

ARE THERE ANY NOTES THAT YOU WANT TO APPEAR ON THE NOTICE OF DECISION?

_____

_____

_____ _____

Signature of Person Completing Form Date

_____ _____

Agency Your Phone Number