



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:

Jane Freeseaman @ jfreeseaman@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