| Application | | |
| --- | --- | --- |
| Applicant Information | | |
| Name: | | |
| Date of birth: | Phone: | |
| Current address: | | |
| City: | State: | ZIP Code: |
| Guardian Information if applicant is a minor | | |
| Name: | | |
| Relationship to Applicant: | | Phone: |
| Address if different: | | |
| City: | State: | ZIP Code: |
| Details of request | | |
| Please select the reason that best matches the nature of your request for funding:□ Seeking reimbursement for mental health services already received (approx. amount: \_\_\_\_\_\_\_\_\_)□ Seeking reimbursement for mental health services that I or a loved one needs Assessments or testing (estimated amount if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)    Co-pays for ongoing mental health counseling (approx. per visit amount if known: \_\_\_\_\_ )    ABA treatment (in-home behavioral supports OR co-pays associated)  *{circle one}*      □ **Seeking reimbursement for other mental health costs: (such as sensory items, residential care, etc.**  **please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  IT IS IMPORTANT THAT YOU ATTACH ANY BILLS, ESTIMATES OR SUPPORTING DOCUMENTATION TO THIS APPLICATION | | |
| Signatures | | |
| I authorize the verification of the information provided on this form. | | |
| Signature of applicant: | | Date: |

***Board Use***: ORIGINAL REVIEW DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ approved \_\_\_ denied\_\_\_\_ pending additional info: \_\_\_

Approved Full amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approved Partial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Denied based on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pending receipt of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_