

CONFIDENTIAL

Authorization #

Wraparound Funding Request Form for Benton and Iowa County Children

Child's Name:	Birth Date:	
Is this child a Benton or Iowa County resident? <input type="checkbox"/> Yes <input type="checkbox"/> No* [*If "No," funding cannot be requested.]		
What is the child's mental health diagnosis? <input type="checkbox"/> Assessment Pending		
Who made this child's diagnosis?		
Provide a brief description of the child / family situation:		
Parent / Guardian Name:		
Address:		
Phone:	Email address:	
What school does this child currently attend?	In what grade is this child?	

Funding Need	Service Provider	\$ Amount
<input type="checkbox"/> Prescription Medication		
<input type="checkbox"/> Respite Care		
<input type="checkbox"/> After School/Summer Activities		
<input type="checkbox"/> Assessment		
<input type="checkbox"/> Other (Describe)		
Additional Requests/Changes ↓	TOTAL AMOUNT REQUESTED →	
	FINAL TOTAL EXPENDITURES →	

Is this an ongoing need ?
What outcomes are expected as a result of the wraparound funding? <input type="checkbox"/> Wraparound funding will help prevent an out of home placement. <input type="checkbox"/> Wraparound funding will reduce the length of stay in placement. <input type="checkbox"/> Wraparound funding will assist a child returning home from placement. <input type="checkbox"/> Wraparound funding will prevent a child from becoming expelled from school or dis-enrolled from another community program. <input type="checkbox"/> Other (Describe)
Have ALL other funding resources been explored i.e., Hawk I, T19, Private insurance)? Please explain below:
Name of referring worker: Agency (if applicable): Phone: Does this child meet the Iowa definition of SED (Serious Emotional Disturbance)? <input type="checkbox"/> Yes <input type="checkbox"/> No* [*If "No," an assessment must be pending.]

RELEASE OF INFORMATION STATEMENT:

I understand that protected mental health information is being released to Benton-Iowa Wraparound Fund oversight committee. I authorize the release or exchange of relevant information among agencies for the purposes of coordinating community services. I understand that Federal Law prohibits any further disclosure of this information.

Parent/Guardian Signature _____ Date _____

Forward this form to the SED Service Coordinator for funding authorization:

Attn: Patricia Gilbaugh, Ph.D., LMSW
 P.O. Box 4
 Van Horne, IA 52346
 Phone: (319) 361-6529
 help@advocatecenter.org

Authorization Signature:	FOR OFFICE USE ONLY!
Date:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied