

DHHS Community Case Management Funding Request Form

**This form will be utilized in accordance with the OACPDS Waiting List Management Policy

Client Name:	Date:
Maine Care #:	CCM Agency:
Social Security#:	Case Manager:
Telephone #:	Telephone #:
Address:	E-mail Address:
DOB:	

Service(s) requested (Please check all that apply):

<input type="checkbox"/> Free Standing Day Habilitation		Agency Name:	
Community Based Program:	\$	Per Diem Rate	Billing Days Per Year (TOTAL)
Description of Service:			
Diagnosis			
Start Date:		Amount of Approval:	
*Attach Consumer Plan/Reason for Need and Budget			

<input type="checkbox"/> Long Term Supported Employment		Agency Name:	
\$	Hourly Rate:	Number of Hours per Week:	Weeks per year:
Description of Service:			
Start Date:		Amount of Approval:	
*Attach Proposal/Reason for Need and Budget:			

<input type="checkbox"/> Discretionary Fund Request <input type="checkbox"/> Flexible Fund Request	Vendor Name: Vendor Phone #: Vendor Address: Vendor ID#:
Total Amount Requested: \$ Total Amount Approved: \$	
Description of Service(s):	
*Attach Proposal/Justification for Service & make sure the consumer plan identifies the services requested: (include current services, new services requested, dates needed, and estimated cost for all services requested):	

Signature of CCM Supervisor

Date

Signature of CCM Liaison

Date

DHHS/MR Services Approval

Approval Date