**Please complete all sections. INCOMPLETE FORMS WILL BE DENIED AND RETURNED**

**Please print legibly.**

Consumer Name: DOB:





Address: County:



Telephone #: Social Security #:



Veteran: Yes No Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language:

Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown



Is client a consumer of Public Behavioral Health Services? Yes No

Is client receiving treatment for a substance use disorder? Yes No

Is consumer presently receiving mental health services? Yes No



**Pick-up Location:**  **Drop-off Location:**



**Roundtrip Yes No**

**Please provide a detailed description of the transportation assistance needed.**

**Please list all agencies such as DSS and other charitable organizations that have been contacted and note reason for refusal: Must have contacted a minimum of 3 agencies.**

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:

Result:

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:

Result:

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:

Result: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If additional agencies contacted list the name, number contact person and result.





**Total dollar amount requested:**



Funding is needed by:

Check should be made payable to:

Name:

Address:

Telephone #:

Tax I.D. #:

**Consumer Signature:** **Behavioral Health** **Provider Signature**:

Telephone/Email Telephone/Email

**Consumer Name:**

**CSA USE ONLY**

**Approved Amount:**  **Denied:** **Withdrawn:** **Date:**

**Special Need Funds:**

**Comment:**

**Signature of staff processing request:**

**Executive Director, Behavioral Health Coordinator Manager, or Board President Signature:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BHA Approval (if request is over $1000.00):**

**CSA Special Needs Request Notes:**