

EASTERN MISSOURI AUTISM PROJECT (EMAP) FUNDING REQUEST

FY 20

Name: _____
 DMH ID#: _____
 DOB: _____ AGE: _____

Date of Request: _____
 Support Coordinator: _____
 Team: _____ SC Phone #: _____

STATUS:	In Project:	Initial:	Annual:	Amendment:
	1 Time / Emergency Funding:		On Waiting List:	PON:

Complete the following section for each service:

Funding <i>(check one for each service)</i>		Provider	Service	*Service Code	Frequency or Length	Total Cost
POS CFF						

*If funding is CFF and payment is to be made to a family or a provider whose service does not have a service code, put NA (not applicable).

TOTAL REQUEST	
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The following items *MUST* be provided before a request can be processed:

St. Louis Regional Office Budget Sheet attached (County/Tri-County)?	<input type="checkbox"/>	Choices for Families – Monthly Reimbursement Form or Voucher (If applicable)	<input type="checkbox"/>	Supervisor Signature:	
UR Recommendation sheet attached?	<input type="checkbox"/>			EMAP Coord. initials:	
Approved: <input type="checkbox"/>	Denied: <input type="checkbox"/> Reason: _____				