Supports Coordinator: _____

# 202 Funding Request Form

Participant Name: _____
First M. I. Last

Address _____ _____
Physical/ Street Address City/Town State Zip Code

Phone Number: _____ Date of Birth: _____ Age: _____

Assessment Date: _____ Primary Diagnosis: _____

Financial Information: Income: _____ Assets: _____ Medicaid Application Filed? ☐ Yes ☐ No

Will this participant be financially eligible for the MI Choice Waiver in the future? ☐ Yes ☐ No

Estimated Date of Waiver Enrollment (if applicable): _____

Detailed Rationale/Need for Services (Include summary of functional needs/limitations, service needs, and risk factors):

Current grant services: ☐ Yes ☐ No If yes, Service & Provider information: _____

**Services Requested:**

- ☐ Home Care Assistance (CLS)
- ☐ Medication Management
- ☐ Assistive Devices and Technology (PERS)
- ☐ Respite
- ☐ Home Injury Control (DME)
- ☐ Training Materials (SD only)
- ☐ Transportation
- ☐ Adult Day Services
- ☐ Liquid Supplements
- ☐ Chore Service
- ☐ Home Delivered Meals
  *in special circumstances only - MUST have director approval

Total Estimated Monthly Cost: _____ Proposed Start Date: _____

_____ _____
Supports Coordinator Signature Date

_____ _____
LTC Program Director Signature (signifies approval) Date

**Please Return Completed Form with Care Plan Budget form to Terry LaFave**