**Consumer Name:**        Click here to enter text.                  **Date:** Click here to enter text.

**EIS #:**               Click here to enter text.                               **Receiving Waiver Services?** Yes  No

**DOB:**               Click here to enter text.**If “Yes”, please specify:**  Click here to enter text.

…………………………………………………………………………………………………………………………………………………………………

**Case Manager (CM) Name:** Click here to enter text. **CM Agency:** Click here to enter text.

**CM Address:** Click here to enter text. **CM Phone:** Click here to enter text.

**CM Fax:** Click here to enter text.  **CM Email:** Click here to enter text.

 …………………………………………………………………………………………………………………………………………………………………

**Amount of Request:** Click here to enter text.

**Describe items/services requested:** Click here to enter text.

**Justification for request**: Click here to enter text.

**Have all available funding options been explored?** Yes  No

**Describe options explored**: Click here to enter text.

**Consumer (or family) able to contribute**? Yes  No

**If “No”, please describe budgetary constraints:** Click here to enter text.

**CM verification funding need is documented in Person Centered Plan:** Yes  No

 …………………………………………………………………………………………………………………………………………………………………

**Vendor Name:** Click here to enter text. **Vendor ID #:** Click here to enter text.

**Vendor Address:** Click here to enter text. **Vendor Phone:** Click here to enter text.

**Vendor Email:** Click here to enter text. **Vendor Fax:** Click here to enter text.

 …………………………………………………………………………………………………………………………………………………………………

Approved? Yes  No  Billing Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DHHS Signature: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_