CRITICAL NEED FUNDS
REQUEST FORM

Individual Name:	
Support Services Coordinator Name:	
Date of Request:	
Total Amount of Request	
Last use of funds (mo/yyyy) (Item/s)	
Copay percentage	

"Critical Need" requests must meet all criteria below. In addition, expenses must be related directly to the health and/or safety of the Individual, no other resource is available to financially assist, and the household cannot make further contributions without incurring hardship and is unable to meet the need.

Area of Request

(Specify the area of need)

☐ Educational
☐ Housing related
☐ Medical/ Mental Health
☐ Social/ Recreational
☐ Respite
☐ Other (explain): _____

Other Resources Contacted/ Alternate Resources Explored

Critical Need Funds are a payer of last resort. Please note the date that other resources were contacted as well as the outcome. If the resource is not appropriate for the need, indicate n/a

Alternate Resource	Date (or n/a)	Outcome
Community Action		
Family Council/ Cluster		
MCDJFS		
HELP House		
Religious Organization		
Patient Assistance Programs/ HCAP		
Health Insurance		
Waiver Funding/ Medicaid		
Mental Health		
Other (specify):		

Details of Request

Provide detailed information regarding the request including breakdown of costs, vendor name/ contact information, frequency of expenditure and preferred method of distribution.

Justification for Request

What health and/or safety risks will this request alleviate? What are the individual's/ family's future plans to prevent this need from reoccurring?

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if my application is approved, any false statements, omissions, or other misrepresentations made on this application may result in future ineligibility for Critical Need Funds.

Print Name	Signature	Date

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Recommendation of Committee Members:

☐ Approve ☐ Disapprove

Print Name	Signature	Date

Family Support Services Director Review

☐ Agree with committee recommendation ☐ Disagree with committee recommendation

Name (Printed): _____

Signature: _____

Date: _____

Admin Initials: _____

Current CNF balance: _____

☐ Copy for individuals file

☐ Copy for tracking log