Funding Request Form

Champaign County Family & Children First Council
Intersystem Services Agreement

Youth Name: Youth DOB:

Parent Name: Date of Request:

Who is Primary Physician:

Request Submitted By:

Agency Submitting:

Type of Child Family Team (CFT):

☐ Formal CFT–Wrap-A-Round ☐ Informal CFT

Identified Unmet Need by CFT (justification of need)**:**

Description of Service/Placement to be delivered and tie to treatment goals:
(dates, times, costs, etc.)**:**

List other services/ Resources exhausted:

Agreed Upon Term of Service/Placement ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other
Is Youth Medicaid Eligible: ☐ Yes ☐ No
Is Youth Covered by Insurance: ☐ Yes ☐ No

Estimated cost of Service: $_____

Vendor Payment/ purchase information (if requesting funding and not service)**:**

Name:

Address:

Phone #: **Email:**

Family and Children First Council Use Only	
Fund to be utilized:	☐ SOC-FCSS ☐ Pooled Funds ☐ Other:
Service Requested:	☐ Parent Coaching ☐ Youth Mentoring ☐ Respite ☐ Gas Voucher ☐ Family Supportive Services* ☐ Other:

*Family Support may include family/ youth incentives/ rewards, behavior modification supplies, enrichment/bonding activities, etc.

Diversion Team Agency Contact Name:

Agency Director Approval: **Date:**