

**Family Support Services Program  
Allocation Request Form**

**\*VERY IMPORTANT\***

\*Please fill out ALL the information below, if any part of the required information is not complete, this form will be returned for full completion\*.

Date: _____	Address: _____
Name of person receiving services: _____	City/Zip Code: _____
Date of Birth: _____	Phone number: _____
Parent/Guardian name: _____	SS#: _____
Disability: _____	Insurance type ( <b>Please circle all that apply</b> ): PRIVATE /MEDICAID/ CHP+/ HCP/ NONE OTHER: _____
Submitted by: _____	Phone number: _____
<b>Email:</b> _____	
<b>Please identify the level of need you were assessed at:</b>	
<input type="checkbox"/> High Most <input type="checkbox"/> Moderate Most <input type="checkbox"/> Low Most <input type="checkbox"/> Moderate <input type="checkbox"/> Least	
If you checked least or moderate, only emergency funding is available. Please identify, below, the circumstances that warrant the emergency.	
_____	
_____	

**Type and dollar amount of service requested**

Please check all services you are applying for and identify each service

- |                          |  |                               |
|--------------------------|--|-------------------------------|
| <input type="checkbox"/> | <b>Professional services</b> _____   | <b>Amount requested</b> _____ |
|                          | Examples: Speech/Language, Occupational/ Physical therapies                    |                               |
| <input type="checkbox"/> | <b>Medical/Dental</b> _____  | <b>Amount requested</b> _____ |
|                          | Examples: Co-pays, medications, eyeglasses - all must be related to disability |                               |
| <input type="checkbox"/> | <b>Transportation</b> _____  | <b>Amount requested</b> _____ |
|                          | Examples: Mileage (to and from appointments related to disability)             |                               |
| <input type="checkbox"/> | <b>Family Other</b> _____  | <b>Amount requested</b> _____ |
|                          | Examples: Specialized diet, diapers, specialized clothing                      |                               |
| <input type="checkbox"/> | <b>Assistive Technology</b> _____  | <b>Amount requested</b> _____ |
|                          | Examples: Hearing aids, communication devices                                  |                               |
| <input type="checkbox"/> | <b>Home modification</b> _____   | <b>Amount requested</b> _____ |
|                          | Examples: Widened doorframe, wheelchair ramps, safety devices                  |                               |
| <input type="checkbox"/> | <b>Parent/sibling support</b> _____  | <b>Amount requested</b> _____ |
|                          | Examples: Counseling services, recreation, sibling respite                     |                               |
| <input type="checkbox"/> | <b>*Respite (SEE BELOW)</b> _____  | <b>Amount requested</b> _____ |

\*If requesting respite, you must fill out the information below, if this is incomplete your request will not be processed. Please indicate how respite is related to your child's disability\*. Check all that apply or complete the other category.

- My child is over the age of 13 and requires supervision because of health and safety needs.
- Because of my child's disability, I have to pay the respite provider over and above what I would if my child did not have a disability. Please request only the additional expense.
- Because of the level of my child's needs related to his/her disability, I need to get occasional and routine breaks. Please, also indicate, related to your child's disability, what causes the need for routine breaks (i.e. hitting, property destruction, line-of-sight supervision etc.)
- Other \_\_\_\_\_

**Please indicate other resources pursued (if applicable) for the above requests (e.g. Private Insurance, Medicaid, WIC, etc)**

**PLEASE SUBMIT FORM TO JENNIFER REMMERS AT P.O. BOX 200069/1050 37<sup>TH</sup> ST. EVANS, Co. 80620**