Allegany County Mental Health System's Office (CSA)

Client Support Funding Request

Name:_____ SS#:_____ Date: _____ DOB:_____

Axis I Diagnosis: _____ Address: _____

$ Requested: $_____ Payment made to: _____

Vendor Address & Phone: _____

Provider/Staff Making Request & Phone: _____

How funds will be used: _____

_____

_____

_____

Other Resources Explored/Unavailable/Why must use Client Support Funding: _____

_____

_____

_____

How will use of funding assist client in remaining in the community/prevent hospitalization or incarceration? _____

_____

_____

_____

Approved ____ Denied _____ Comments: _____

_____

_____

_____

_____ _____

MHSO (CSA) Designee **Date**

_____ _____

MHSO (CSA) Director or Designee **Date**

If request exceeds $500.00, attach document reflecting MHA approval.