REGIONAL CARE TEAM

MDOC Care Funds Request Form

Date of Request: _____

Region: _____

Client Information

Name: _____

MDOC #: _____

Telephone #: _____

Referral Source (Person/Agency): _____

_____

Vendor Name: _____

Billing Address: _____

Telephone #: _____

Referral Contact Info: _____

Fiscal Agent: ☐ The Opportunity Alliance ☐ Wings for Children & Families

Check all areas of need youth is encountering:

(check all that apply)

- ☐ Housing ($1500.00)
- ☐ Family/Relationships ($500.00)
- ☐ Prosocial Activities ($500.00)
- ☐ Emotional/Psychological ($500.00)
- ☐ Education/Vocation ($500.00)
- ☐ Employment ($500.00)
- ☐ Transportation ($1200.00)
- ☐ Safety ($500.00)
- ☐ Legal ($500.00)
- ☐ Medical ($500.00)
- ☐ Cultural/Spiritual ($500.00)
- ☐ Treatment ($500.00)
- ☐ Other (Specify): ($500.00)

Please provide a brief narrative of the youth's need(s):

_____

_____

_____

_____

Please provide a brief description of the service requested/items to purchase (if applicable include the quantity/duration/cost per unit of service):

_____

_____

_____

Total Amount Requested: _____ **Emergency**: ☐ Yes ☐ No

Does this service (case review) aid in the prevention of secure detention/commitment: ☐ Yes ☐ No

Other Pertinent Information: _____

_____

_____

Signature:

Referral Source: _____ Date: _____

INTERNAL USE ONLY

☐ Processed/Approved Date Processed: _____

☐ Need more information Date Returned: _____

☐ Other resources Identified (specify): _____

_____

Fiscal Person signature: _____ Date: _____