__________________COUNTY CENTRAL POINT OF COORDINATION (CPC)
Funding Agreement (This is not a bill)

***Individual Information:**

Name: ______________________________ Diagnosis: ________ Ph#: ______________

Address: ____
Street City State ZIP

SSN#: ______________________ SID#: _______________ DOB: ______________

***Provider Information:**

Provider Agency: ___________________________ Phone: ______________________

Address: ____
Street City State Zip

***Service Information:**

Type of Service requested: ____

Total # of Units Requested: ________ Type of Unit (temporary, hourly, daily, monthly): ______________

Unit Rate: ______________ Service Code (if applicable): ______________________

Requested effective start date: ______________ Requested expiration date: ______________

***Funding Information:**

Total County funded Fees: ______________________________

Total Medicaid funded Fees: ______________________________

Total other funded Fees: ______________________________

Total Fees: ______________________________

Submitted by: ____
Signature **Title/Agency** **Date**

NOTICE TO SUBMITTING TCM/SW: This form should always be accompanied with a Site or Hourly Budget Detail form annually or if any changes occur. In addition, a statement of justification must accompany if changes occur such as rate or service increases. No requests will be processed without these forms!

For CPC Office Use only:

- ☐ **Funding Approved**
- ☐ **Funding Approved with Changes (see comments below)**
- ☐ **Partial Funding Approved (see comments below)**
- ☐ **Funding Denied (see comments below)**
- ☐ **Pending (see comments below)**
- ☐ **No action taken (see comments below)**

Comments:

____
____
____
____
____

CPC Signature: ____
Signature **Date**

NOTICE TO CLIENTS ONLY: The appeals process is attached or on the reverse side of this page if serving as a Notice of Decision (NOD) and is sent to the client.