WASHINGTON COUNTY MENTAL HEALTH DISABILITY SERVICES
County Funded Service Request Form

Date of Request: _____

Client's Name: _____

_____

Current Hours and Services: _____

_____

Additional Hours and Services Requested: _____

_____

Requested Start Date: _____ **End Date:** _____

Duration for Service Request: _____

Purpose for Request for Change/Addition in Service(s) (Please specify how the hours of service will be used and the reason for the need of the requested services. Additionally, attach any contact notes, narratives, etc. that support the County being the payer of last resort and/or exhaustion of natural supports): _____

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Signature of Individual/Legal Guardian: _____

Person Completing the Request: _____

Date Completed: _____