St. Clair County Community Mental Health

Request for Wraparound Services "Gap Pool" Funds

Child's Name: _____ Case #: _____ Date: _____

Request Details

Description of Need:

_____

How does meeting this need help with the Wraparound Goal/Outcome?

_____

_____

Estimated Cost of Need: _____ ☐ Estimate Secured & Proof Attached

List resources that were researched prior to request:

_____

What will the impact to the family be if not approved?

_____

Any Additional Needs Anticipated in the Future?

_____

Was request discussed at the Child & Family Team Meeting? ☐ Yes ☐ No

Teams Support Request? ☐ Yes ☐ No

Signatures & Request Decision

Community Team Decision: ☐ Approved ☐ Denied Date: _____

_____ _____ _____

Wraparound Coordinator Signature/Credentials Print Name Date

_____ _____ _____

Wraparound Supervisor Signature/Credentials Print Name Date

Additional Suggestions/Resource(s) for the Family:

_____

Distribution of Funds:

Directions: Please fill out the following section in its entirety to ensure timely distribution of funds.		
Make Check Payable to:		
Date of Request:	Check Amount: **$**	
Select One: ☐ Mail Out Check* ☐ Return Check to Requestor		
***If selecting mail option, please list address for mailing below:**		
Street Address:		
Apt, Lot, Suite, etc.:		
City:	State:	Zip:

Funds Received by Parent/Guardian

I, _____ have received _____, totaling $_____.

(Parent/Guardian) (Item/Service)

_____ _____ _____

Parent/Guardian Signature Print Name Date