St. Clair County Community Mental Health Authority

Request For Wraparound Services "Gap Pool" Funds

Case Holder: _____ Case #: _____ Date: _____

Child's Name: _____ School: _____ Age: _____

Description of need: _____

How does meeting this need help meet Wraparound goal/outcome? _____

_____

_____

Estimated cost of need: _____

List resources that were researched prior to request: _____

_____

Activities Performed (check all that apply):

☐ Estimates Secured & Attached: _____

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

_____

Anticipated Additional Needs: _____

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

Team supports request: Yes ☐ No ☐

Wraparound Coordinator Signature: _____ Date: _____

Wraparound Supervisor Signature: _____ Date: _____

Community Team: ☐ Approves ☐ Denies Date: _____

Additional Suggestions or Resource for the family:

TO BE COMPLETED WHEN FUNDS RECEIVED BY PARENT/GUARDIAN

I, _____ (Parent/Guardian), have received _____ (Item/Service), totaling $_____.

_____ Date: _____

Parent/Guardian Signature

☐ Receipt/Documentation attached