SOUTHEAST IOWA LINK
MENTAL HEALTH DISABILITY SERVICES
Request for Service Funding

Date of Request: _____

Applicant's Name: _____ **SSN#:** _____
Last **First** **DOB:** _____

Current Provider(s): _____

Current Hour(s) and Service(s): _____
_____
_____

Additional Hour(s) and Service(s) Requested: _____
_____
_____

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

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 Region being the payer of last resort and/or exhaustion of natural supports): _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Applicant's Signature (or Legal Guardian): _____ **Date:** _____

Person Completing the Request: _____ **Date:** _____

Contact Information (Address, Phone Number, Email):
_____
_____

****The completed Functional Assessment must be included with the Request for Service Funding****