**MOUNTAIN STATE FAMILY ALLIANCE**
**MENTAL HEALTH SUPPORT SERVICES (MHSS) REQUEST FORM**
**MUST attach copy of the signed treatment plan which indicates those services above you have requested for the child.**
**A new MHSS Request must be submitted every 90 days in order for services to continue.**

Child's Name: ______________________________ Caretaker Name & Address: ______________________________

Phone: ______________________________ ______________________________

Has this child been in out-of-state placement within the last 90 days? Yes or No

| Category | Cost Per Session | Sessions Requested | Total $ Requested | Provider Name & Address | Service Description |
|---|---|---|---|---|---|
| Supervision<br>☐ IEP ☐ SA | | | | | |
| Therapy<br>☐ SA | | | | | |
| Basic Living Needs<br>☐ SA | | | | | |
| Clinical Assessment<br>☐ SA | | | | | |
| Transportation<br>☐ IEP ☐ SA | | | | | |
| Mentoring<br>☐ IEP ☐ SA | | | | | |
| Tutoring<br>☐ IEP ☐ SA | | | | | |
| Training<br>☐ SA | | | | | |
| Respite<br>☐ SA | | | | | |
| Recreation<br>☐ SA | | | | | |
| Wraparound<br>☐ SA | | | | | |
| Other<br>☐ SA | | | | | |

**Total Requested:** ____________________ **Dates of Service:** __________ **to** __________ ☐**Initial** ☐**Re-Authorization**

☐**Continuation of IEP services (no changes)**

____________
**KCC Initials**

______________________________ ____________ ______________________________
**Signature** **Date** **Agency**

**OFFICE USE ONLY**

**Choose One:** One Time Check or Emergency Funding **For Check Distribution Send to:** Caretaker Vendor Provider Invoice

☐ Approved ☐ Approved, Emergency 30 days only ☐ Denied____________________

______________________________ ____________
**Authorized Signature** **Date**

**Revised 2/3/2005**