DAP Funding Request Narrative Form

**Patient Name**: Click or tap here to enter text.

Requestor Name: **Click or tap here to enter text.** CSB: **Choose an item.**

Date of request:**Click or tap to enter a date.** Plan Start Date: **Click or tap to enter a date.**

Type of Funds: **Choose an item.** Civil [ ]  or NGRI [ ]

Is this a plan modification? **Choose an item.** If Yes: Amount of Original Plan: **Click or tap here to enter text.**

Requested Amount: **Click or tap here to enter text.**

Is this an out of catchment plan? **Choose an item.** Out of Catchment referral been completed? **Choose an item.**

Has the receiving CSB DAP coordinator been consulted? **Choose an item.**

If Yes, Who was consulted? **Click or tap here to enter text.** Date of Consultation **Click or tap to enter a date.**

If no, why? **Click or tap here to enter text.**

Hospital: **Choose an item.** Age Group **Choose an item.**

Admission Date: **Click or tap to enter a date.** D/C Readiness Level:**Choose an item.**

Discharge Readiness Date: **Click or tap to enter a date.** Scheduled Discharge Date **Click or tap to enter a date.**

Patient Resources:

Person responsible for acquisition of benefits: **Click or tap here to enter text.**

Auxiliary Grant Eligible: **Choose an item.** ID/DD **Choose an item.** Waiver Status: **Choose an item.**

VA Benefits **Choose an item.** Medicaid [ ] . Medicare [ ]

Income **Click or tap here to enter text.** Other  **or tap here to enter text.**

Brief Description of discharge barriers:  **or tap here to enter text.**

What alternatives to DAP have been attempted (For residential placements please include which facilities that accept alternative payment sources have been attempted): **Click or tap here to enter text.**

Other outstanding clinical needs to consider:  **or tap here to enter text.**

What is the plan to step the person down off DAP? **Click or tap here to enter text.**

Residential Provider: **Click or tap here to enter text.**

Memory Care Placement: **Choose an item.** Approval by DBHDS Community Transition Specialist: **Choose an item.**

Date of approval by DBHDS: **Click or tap to enter a date.**

Description of expenses to be paid by DAP (If requesting over and above the AG amount, a detailed breakout of costs and services provided is required, along with clinical information supporting the enhanced level of care.) : **Click or tap here to enter text.**

For Use by Regional Office: Date Received:Click or tap to enter a date. Approved [ ]  Denied [ ]  Date: Click or tap to enter a date.

Amount needed this FY: Click or tap here to enter text.