**WMPC Funding Request for Counseling**

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| Name of Client:  | MiSACWIS Case ID: |
| MiSACWIS Person ID:  | Agency:  |
| Foster Care Worker Name:  | Foster Care Worker Email Address:  |

Service Needed:

Name of Service Provider:

Number of Units Requested and Cost for Service:

1. Does client have private insurance? If yes, why is private insurance not being utilized to pay for this service?
2. Does the client have Medicaid? If yes, why is Medicaid not being utilized to pay for this service? If the client does not have Medicaid, what efforts have you made to help the client apply for Medicaid?
3. Has the client contacted Network 180? If service was denied, please state below and provide the WMPC Care Coordinator with a copy of the denial letter upon receipt. \*Please note that this form can be completed and returned to the WMPC prior to receipt of the denial letter\*

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| PAFC Worker Signature: | Date: |
| PAFC Supervisor Signature:  | Date: |

**Approval:**

[ ]  Request **approved** by the WMPC. The WMPC agrees to provide payment for the following service:

[ ]  Request **denied** by the WMPC due to the following reasons:

