Funding Request Instructions

Families can receive up to $1,250 of flexible funding in a 12-month period. If the cost of the good/ service is above this, an explanation must be provided for how the family will pay the remaining balance that CMP cannot pay for. This funding cannot be used to pay for any housing costs or car insurance, and must be able to show how the funding may prevent out of home placement into DHS custody and/or commitment to DYS. Funding cannot be used to reimburse families for any cost incurred and must be requested prior to services rendered.

Please complete all fields and the release of information (ROI). Only highlighted fields must be completed on the ROI. If the form is incomplete, the request will not be considered.

Please include an invoice or some other document showing the cost of the goods/ services. For car repairs, please include a copy of the person's driver's license, insurance, and registration. These must be current to pay for any car repairs. Please also include whether the vehicle is the only vehicle and please ensure that the vehicle will be drivable after the requested repairs.

Funding requests are discussed on Thursdays, and all documents must be provided by the end of the day that Tuesday to be staffed the same week. Funding requests may take up to 2 weeks to be approved or denied.

If you have any questions or are unsure if funding is appropriate, please reach out to Abby Leinbach at abigaill@htop.org or (970) 244-0602.

Demographic Questions Guide

Below are the options for each demographic question. If you choose to fill out the fillable form, these options are already listed in a dropdown box. Please include the most accurate and appropriate selection for each question. If the family feels uncomfortable providing this information, prefer not to say is an option.

Race- Hispanic or Latino/a/x/o or Spanish Origin of Any Race, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, Black or African American, White, Middle Eastern, North African, South Asian, Two or More Races, Prefer Not to Say

Ethnicity- Hispanic, Non-Hispanic, Middle Eastern, North African, South Asian, Prefer Not to Say

Disability Status- Yes has a disability, No does not have a disability, Unknown

Gender- Female (Cis), Male (Cis), Female (Trans), Male (Trans) Gender Neutral, Non-Binary, Agender, Questioning, Prefer Not to Say

Family Adolescent PARTNERSHIP

Funding Request Form

DATE OF REQUEST: _____

Youth: _____ **Gender:** _____ **DOB:** _____

Race: _____ **Ethnicity:** _____ **Disability Status:** _____

Parent/Guardian: _____

Parent/ Guardian

Contact Information: _____ *(address)*

_____ *(city, state, zip)*

_____ ***(primary phone)***

_____ *(email address)*

Sibling Information

Name: _____ **Gender:** _____ **DOB:** _____

Race: _____ **Ethnicity:** _____ **Disability Status** _____

Name: _____ **Gender:** _____ **DOB:** _____

Race: _____ **Ethnicity:** _____ **Disability Status** _____

Name: _____ **Gender** _____ **DOB:** _____

Race: _____ **Ethnicity:** _____ **Disability Status** _____

Name: _____ **Gender:** _____ **DOB:** _____

Race: _____ **Ethnicity:** _____ **Disability Status** _____

Name: _____ **Gender:** _____ **DOB:** _____

Race: _____ **Ethnicity:** _____ **Disability Status** _____

Please include additional sibling information on back.

****All requests must be accompanied by up-to-date, signed FAP Release of Information.**

Current Situation/Goal of Good or Service: _____

_____

_____

_____

_____

_____

Other funding sources tried (All other Funding Sources must be exhausted before using CMP funds): _____

_____

Plan for sustainability (how will the family pay for services once FAP has provided funding?) _____

_____

_____

_____

Does the youth have health insurance? Yes No Insurance Provider: _____

See next page

Requested Provider:_____ Amount Requested:_____

Email: _____

Contact Number:_____

Requested Service:_____

_____

**Please include information about length of service (i.e. # of hrs/wks, total # of weeks)

Referral Source Information

Name: _____ Phone/Cell #: _____

Organization:_____ Email:_____

Please complete all of the fields above.

Date of Staffing/Approval:_____ Amount Approved:_____

Funding Approval:

_____Ariel _____DHS

_____Probation _____CYDC

_____WIOA _____Health Solutions West

_____DYC _____Hilltop

_____SD 51 _____Partners

_____Public Health _____

Please return this **funding request** to the Family & Adolescent Partnership by one of the methods below:

Email to FAPreferrals@htop.org or Fax 970.241-3224

Questions? Concerns? Comments? Please call 970.244.0613 or email at FAPreferrals@htop.org

State of Colorado

Authorization — Consent to Release Information

Agency Requesting Information

Agency Name Family & Adolescent Partnership	Contact Name/Title Abby Leinbach / Coordinator		
Mailing Address 1129 Colorado Avenue			
City Grand Junction		State CO	ZIP 81501
Email abigaill@htop.org	Phone 244-0613	Fax	Date

Client Information

Last Name	First Name	MI
Physical Address		
City	State	ZIP
Permanent Address (if different than physical address)		
City	State	ZIP
Email	Phone	DOB
Type of Identifier: ☐ Other ☐ School ID ☐ DL ☐ State ID ☑ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #: Use only last four digits of SSN if used.	Role:

Consenter/Person Authorizing Consent (if person above is a minor)

Last Name	First Name	MI
Physical Address		
City	State	ZIP
Permanent Address (if different than physical address)		
City	State	ZIP
Email	Phone	DOB
Type of Identifier: ☐ Other ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #: Use only last four digits of SSN if used.	Role:

Authorizes

☑ DHS/ Office: MCDHS
☑ DHS/ Office of Behavioral Health
☑ DHS/ Division of Youth Corrections
☑ Court (Juvenile, County, Municipal)
☑ Service Provider
☑ LEA
☑ School (Private or District)
☑ Probation (Juvenile, County, Municipal)
☑ Diversion
☐ Juvenile Assessment Ctr
☑ SB94
☑ DA

Other Health Solutions West, Rocky Mountain Health Plans, Primary Care Partners, Partners, Public Health, Ariel, Hilltop, Workforce Center

To Release Information to

☑ DHS/ Office: MCDHS
☑ DHS/ Office of Behavioral Health
☑ DHS/ Division of Youth Corrections
☑ Court (Juvenile, County, Municipal)
☑ Service Provider
☑ LEA
☑ School (Private or District)
☑ Probation (Juvenile, County, Municipal)
☑ Diversion
☐ Juvenile Assessment Ctr
☑ SB94
☑ DA

Other Health Solutions West, Rocky Mountain Health Plans, Primary Care Partners, Partners, Public Health, Ariel, Hilltop, Workforce Center

To Receive Information From

☑ DHS Office: MCDHS
☑ DHS/Office of Behavioral Health
☑ DHS/ Division of Youth Corrections
☑ Court (Juvenile, County, Municipal)
☑ Service Provider
☑ LEA
☑ School (Private or District)
☑ Probation (Juvenile, County, Municipal)
☑ Diversion
☐ Juvenile Assessment Ctr
☑ SB94
☑ DA

Other Health Solutions West, Rocky Mountain Health Plans, Primary Care Partners, Partners, Public Health, Ariel, Hilltop, Workforce Center

For the Purpose of

☐ Adjudication
☑ Assessment
☑ Other Implementation and Funding of Services
☑ Coordination of Services
☐ Intake
☐ Insurance (Health/Life)
☑ Interdisciplinary Team Staffing
☐ Placement
☐ Pretrial
☐ Treatment

Type of Information Requested

Education
☑ School Grades/Test Scores
☑ School Attendance Records
☑ School Behavior Reports
☑ IEP's/504

Substance Abuse
☑ Treatment History
☐ Evaluations

Medical
☑ Current Prescriptions
☑ Medical History
☐ Immunizations

Mental Health
☐ MH Assessment
☑ MH Treatment History
☑ Diagnosis

Justice Agency
☑ Probation History
☐ Probation Records
☐ Police Reports/Records
☑ Other Court Records

Other Records
☑ Human Service Records
☐ Child Welfare History

Other (Please Specify) _____

Preparer's Initials _____ **Consenter's Initials** _____

2016 1.1

Instructions: Please update date range of records to be from youth's birthday to at least 6 months from today.
Please update date range of authorization/ consent to be from today to at least 6 months from today.

Date Range of Youth Records	From: Month: 01 Day: 01 Year: 2004	To: Month: 07 Day: 01 Year: 2026
Date Range of Authorization/Consent:	From: Month: 07 Day: 01 Year: 2024	To: Month: 07 Day: 01 Year: 2026
How is this information being released?	☑ Fax ☐ Email ☑ Telephone ☑ In Person ☑ Other FAP databases	

Signature of person authorizing consent: Date: (MM/DD/YYYY)

Type or print name:

Signature of youth: Date: (MM/DD/YYYY)

Type or print name:

☑ By my signature, I consent to the release of information contained on this form for use by the requesting agency(cies). I understand that my records are protected under Federal and State regulations governing confidentiality, 42 part 2, HIPAA , and FERPA and cannot be released without my written consent unless otherwise provided for by the regulations. I understand that any agency or individual using the confidential information or records obtained will take all necessary steps to protect the confidentiality of the above named juvenile/child's identity. I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form.

☐ Consenter declined release of information. _____[staff initial] [Copy Provided to Client]
Date Declined: (MM/DD/YYYY)_____

General

Disclosure Notice to Receiving Agencies: This notice accompanies a disclosure of information concerning a client whose information is protected by HIPAA, 42 part 2, FERPA, or other Federal or State law. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. 42 part 2 and FERPA prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 part 2 or FERPA. A general authorization for the the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of 42 part 2 information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIPAA Redisclosures: Information released under a HIPAA authorization may be subject to redisclosures that do not fall under HIPAA.

Confidentiality Notice for Electronic Transmittal: This release, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. If you have received this communication in error, please immediately notify the sender. In addition, if you have received this in error, do not review, distribute, or copy the document or attachments.

Condition Statement: I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Consent Expiration: This authorization - consent expires on/no later than (specific date), or one year from the date signed, at end of event, completion of treatment, or if included as part of a Court Order or condition of probation, upon the terms specified, whichever is less. Length of time consent is valid can be specific by program or provider, or set by length of program/ referral, period of time that records are utilized for specified consent purpose. See specific agency rules for agency specific time frames for record retention.

Copies of Authorization/Consent Valid: A copy, photocopy, or facsimile transmission of this release will have the same authority as the original.

Parent must be informed of consent rights and right to revoke consent in native language: Under Section 300.9 of Title 34 of the Code of Federal Regulations, parental consent means all of the following: (a) The parent or guardian has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language, or other mode of communication. (b) The parent or guardian understands and agrees in writing to the carrying out of the activity for which his or her consent is sought; and the consent describes that activity and lists the records, if any, that will be released and to whom. (c) The parent or guardian understands that the granting of consent is voluntary on the part of the parent or guardian and may be revoked at any time. If a parent or guardian revokes consent, that revocation is not retroactive to negate an action that has occurred after the consent was given and before the consent was revoked. A public agency is not required to amend the education records of a child to remove any reference to the child's receipt of special education and services if the child's parent or guardian submits a written revocation of consent after the initial provision of special education and related services to the child.

Authorization/Consent Revocation Limitation/Period: This release/authorization may be revoked at any time by written notice to AGENCY, except to the extent that action has already been taken to comply with it. Without such revocation, this release/ authorization will expire as explained. Consenter may revoke consent in writing by contacting the releasing agency. This revocation will be re-corded in the AGENCY record. HIPAA requires written revocation of an authorization to release HIPAA information (45 CFR §164.508(b)(5)). Both Part 2 and HIPAA allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a) (8) and 45 CFR §164.508. If consent is for Substance Abuse Treatment –verbal consent is acceptable. Verbal consent may also be accepted in specific emergency situations. See agency specific policies for more details.

Child Welfare and Medicaid Records: Federal law requires states to exchange information electronically through the state's automated child welfare and Medicaid systems to the extent it is feasible (45 C.F.R. § 1355.53(b) (2) (2009)) and encourages automated data exchange between child welfare and the courts. (45 C.F.R. § 1355.53(d) (2009).

Any information shared and gathered by this program prior to the expiration or revocation of this release may continue to be used by the program for statistical and program evaluation purposes.

Questions: If you have questions concerning this release please call (PROVIDER AGENCY PHONE #) or Please Send Information to: (PROVIDER AGENCY NAME AND ADDRESS AND FAX) Under the State of Colorado and Federal Confidentiality Regulations, no information about a juvenile participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order. If applicable, a minimum necessary determination has been applied to this release/ authorization.

Preparer's Initials | **Consenter's Initials**