

Voucher Request Form

CFP Community Response Mental Health Vouchers for Youth

Please Send Platte, Colfax, Boone or Nance County Referrals (or Questions) to:

Community Response Navigation Assistant

Phone: 402-276-0378 **Email:** rkabes@columbusunitedway.com

*Not Redeemable for Cash. Voucher **expiration date is within 3 months** of date on this Voucher Request Form. THE FIRST APPOINTMENT SHOULD BE SCHEDULED BY EXPIRATION.*

Date: _____

Name of Youth Receiving Vouchers: _____

Parent Name: _____

*(As listed on CR Intake forms; **THE FORMS MUST BE COMPLETED WITH THE PARENT AS THE CLIENT UNLESS 18 YEARS OLD OR OLDER – PLEASE REVIEW TO MAKE SURE ALL QUESTIONS HAVE BEEN ANSWERED AND SIGNED AS APPROPRIATE**)*

Mental Health Provider (from approved list): _____
(agency name not individual counselor)

Number of sessions requested: _____ (maximum of 10 can be requested)

Does family have insurance coverage for which company will be billed: Yes No

Does family have ability to contribute financially: Yes No

If yes, state family contribution amount for each session: _____

Referral made by (name/organization): _____

CR referral form for coaching submitted (MUST PROVIDE CR BROCHURE AND OFFER COACHING TO FAMILY; is okay if they refuse this part of the service): Yes No

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