

**CONFIDENTIAL PATIENT
INFORMATION: See
California Welfare and
Institutions Code Section 5328.**

San Mateo County Behavioral Health and Recovery Services
727 Shasta Street Redwood City CA 94063
Phone: 650.599.1033 FAX: 650.368-4001



**CHILD-YOUTH NMT FLEXIBLE FUNDS
REQUEST AUTHORIZATION FORM**

NMT Assessment Completed: No Yes Date 1 _____ Date 2 _____

Youth's Name		flex			File #	Date		
Male <input type="checkbox"/>	Female <input type="checkbox"/>	DOB			School			
Special Ed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Requestor				Phone		

Agency Involvement	<input type="checkbox"/> Probation	<input type="checkbox"/> Child Welfare	<input type="checkbox"/> Sp Ed	<input type="checkbox"/> GGRC
	<input type="checkbox"/> Other	Indicate		
	<input type="checkbox"/> Private Therapist	Name		

Services Requested

<input type="checkbox"/> Respite Care	<input type="checkbox"/> After-School	<input type="checkbox"/> Family Support	<input type="checkbox"/> Child Support
<input type="checkbox"/> Recreation	<input type="checkbox"/> Crisis Stabilization	Please check one: <input type="checkbox"/> Goods/Supplies <input type="checkbox"/> Services	Please check one: <input type="checkbox"/> Goods/Supplies <input type="checkbox"/> Services
<input type="checkbox"/> Therapy			
<input type="checkbox"/> Other :			

NMT Flexible Services Description/or Funds Requested & Time Period
Why
Outcomes
Utilization Plan

Flexible Funds	\$	Family Contribution	\$
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Youth's Name _____

Disbursement Plan

Issue Check To		Amount	\$
Address to Mail Check		Attn:	
Special Instructions			

Proposed Service Expenditures

Item	Gross Cost	Family Contribution	Mental Health Cost

Authorization Sign Off

Requester	Supervisor	Manager

Parent Signature	Date	HH Signature	Date on File

Parent not available to sign

Requester's Initial