



**SOUTHEAST IOWA LINK (SEIL)
MENTAL HEALTH AND DISABILITY
SERVICES REGION**

DES MOINES, HENRY, JEFFERSON,
KEOKUK, LEE, LOUISA, VAN BUREN
& WASHINGTON COUNTIES

**SOUTHEAST IOWA LINK MENTAL HEALTH AND DISABILITY SERVICE
Request for Service Funding**

Date of Request: _____

Applicant's Name: _____ **SSN#:** _____
Last First DOB: _____

Current Provider(s): _____

Provider, address, telephone and fax numbers of the services requested: _____

Additional Hour(s) and Service(s) Requested: _____

Requested Start Date: _____ **End Date:** _____

Purpose for Request for Change/Addition in Service(s) (Please specify how the hours of service will be used and the reason for the need of the requested services. Additionally, attach any contact notes, narratives, etc. that support the Region being the payer of last resort and/or exhaustion of natural supports): _____

Applicant's Signature (or Legal Guardian): _____ **Date:** _____

Person Completing the Request: _____ **Date:** _____

Contact Information (Address, Phone Number, Email):

****The completed Functional Assessment must be included with the Request for Service Funding****