KCDDD PART C - EXTRAORDINARY EXPENSES FUNDING REQUEST FORM

Agency Name _____ABC Children's Agency_____

Child's Name/Identifier: Client's Name **Date of Birth:** D.O.B. **Name of FRC:** FRC's Name

Submitted By: Name **Phone:** FRC's phone number **Date:** Today's Date

Description:

(Client's Name) has been diagnosed with (Autism Spectum Disorder) which will require (an additional 10.5 hours of intensive services a week) that go above and beyond the services that would be typically provided to a child.

According to his/her IFSP, this child will receive (2.5 hours 3 times/week and 1.5 hours 2 times/week) of Specialized Instruction at (program names) from July 2004 through June 2005.

Children diagnosed with an Autism Spectrum Disorder have been shown to benefit from (intensive, structured one on one services).

Funding Request Grid

Hearing Aids

Calendar Year	Service Months From	Service Months To	# of Hearing Aids	Single Unit Cost per Hr Aid	Sub-Total	# of Earmolds	Cost per Earmold	Sub-Total	Flat Fee	Total	KCDDD Approval	Notes
					$ -		$ 45.00	$ -	$ -	$ -		
					$ -		$ 45.00	$ -	$ -	$ -		
					$ -		$ 45.00	$ -	$ -	$ -		
Sub-Total			0	---	$ -	0	---	$ -	$ -	$ -		

Autism Spectrum Disorder Services

Calendar Year	Service Months From	Service Months To	A.S.D. Services	Cost per month	# of months		Total	KCDDD Approval	Notes
2004	07/01/04	09/30/04	Intensive Autism Services	$ 200.00	3		$ 600.00		
2004	10/01/04	12/31/04	Intensive Autism Services	$ 200.00	3		$ 600.00		
2005	01/01/05	06/30/05	Intensive Autism Services	$ 200.00	6		$ 1,200.00		
Sub-Total				---	12		$ 2,400.00		

Other

Calendar Year	Service Months From	Service Months To	Description		Total	KCDDD Approval	Notes
					$ -		

Total EE Funding Requested **$ 2,400.00**

Approved By: _____ **Date Approved:** _____