



DEPARTMENT OF AGING & DISABILITIES

DEVELOPMENTAL DISABILITY ORGANIZATION

271 W. 3rd St. N., Suite 500, Wichita, KS 67202 • Phone (316) 660-7630 • Fax (316) 660-4911

STEPHEN SHAUGHNESSY, EXECUTIVE DIRECTOR • SEDGWICKCOUNTY.ORG

FundingRequests@sedgwick.gov

Direct Financial Assistance Request

☐ Incidental Consumer Supports (\$2,000 max per fiscal year)

☐ One-Time Funds (\$10,000 max per fiscal year; when available)

Date:

Current Funding:

Name

Day:

DOB:

Medicaid? Yes ☐ No ☐

Residential:

SSN:

Insurance? Yes ☐ No ☐

Personal Care Services:

Child Assessment Score:

Specialized Medical:

Tier: ☐ Insurance Provider/MCO, if applicable:

Unserved: ☐

TCM & Agency Name:

TCM Phone #:

Amount Requested:

List requested items (see Funding Committee Guide for additional details):

If requesting incontinence protection (adult briefs/diapers), please indicate the number of product(s) used in a typical month:

Item - Brand Name/Description	Size	Amount / Package Size	Item Cost

Justification for request:

Persons living in the home and relationship to applicant (include additional members on another sheet, if needed). If the individual lives in a congregate setting, roommate information is not necessary.

Name	Relationship	Age	Employed	Receives IDD Services

Please include income/expense information to determine ability to "self-fund" the requested service. Income information is required for all individuals living in the home unless the individual requesting funding is over the age of 18.

Average Monthly Income (Gross)			
SSI/SSDI		Employment	
Family Support/Subsidy		Alimony/Child Support	
General Assistance		Trust Fund/Adoption Subsidy	
Temporary Aid for Needy Families (TANF)		Food Stamps (Vision Card)	
Other (Please explain below)		Average Monthly Income	
		Average Annual Income	

Average Monthly Expenses			
Mortgage/Rent		Electric/Gas	
Phone/Cable		Water/Trash	
Food/Laundry		Alimony Paid/Child Support	
Transportation (payment, gas, insurance, etc.)		Childcare	
Insurance		Savings	
Retirement		Investments	
Other Payroll Deductions		Average Monthly Expenses	
Other (please explain below)		Average Annual Expenses	

If receiving SSI/SSDI, who is the person's payee?

Other Funding Sources Attempted

Name of Source	Amount of Funds Obtained	Amount Denied (please include copy of denial notice, if applicable)

Reminder: United Way of the Plains is a valuable community resource. Resources can be accessed 3 ways: searching online, calling 211 or texting the individual's zip code to 898211.

Required if requesting dental, health, or durable medical equipment (Durable medical equipment is defined as tools which are used in the patient's home and are designed to help improve the quality of life for someone with a medical condition. A back brace or a wheelchair is an example of durable medical equipment):

Contact the consumer's MCO to see if Medicaid will pay.

Date Contacted:

Response (did MCO provide other options or Value Added Services; please explain):

Additional Information:

By signing below, I confirm the information provided is accurate and consent to the submission of this request and supporting documentation to the Sedgwick County Developmental Disability Organization (SCDDO) Funding Committee for review.

Date

Signature of Individual/Individual's Representative

Printed name of Individual/Individual's Representative and if a representative, the relationship to Individual