

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

**CLIENT SERVICES TRUST FUND
APPLICATION FOR ONE-TIME ASSISTANCE**

CLIENT'S NAME (Last, First, M.I.)	BIRTHDATE	AGE	AREA CODE AND PHONE NO.
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CLIENT'S ADDRESS (No., Street, City, State, ZIP)

CLIENT'S ASSISTS NUMBER	DATE OF REQUEST
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SUPPORT COORDINATOR'S NAME	AREA CODE AND PHONE NO.	AMOUNT REQUESTED	PROGRAM ELIGIBILITY (Circle all that apply)
		\$	ALTCS DD SSI

What will the funds be used for (Must include a copy of two estimates):

Describe the reason(s) for requesting assistance (List any extenuating circumstances such as health status, parental age, complexity of the individual's needs and the stress level this places on the family and their ability to respond to that stress.):

Describe client/family member's cost contribution/in-kind support. (List amount of financial contribution and/or the specific type of in-kind support offered.):

Describe alternative resources explored, please be specific. (Request for medical or dental funding must include a copy of medical provider's denial.):

Please list all services/supports the client is currently receiving from the Division of Developmental Disabilities (Division).

CLIENT SERVICES TRUST FUND REQUEST

I request a one-time payment in the amount of \$ _____ .

Client Services Trust Fund payment would be received by:

PAYEE'S NAME (Last, First, M.I.)	SOC. SEC. NO./FEI NO.	RELATIONSHIP TO APPLICANT
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PAYEE'S ADDRESS (No., Street, City, State, ZIP)

CLIENT SERVICES TRUST FUND AGREEMENT

Client/family agreement: I/we agree to use approved Client Services Trust Funds according to this request. I/we agree to return to the Division all unspent funds received, and to furnish receipts to the Division documenting all expenditures. I/we agree to notify the Division support coordinator in a timely manner of any changes in contributions, income or other circumstances that may affect this agreement.

CLIENT/RESPONSIBLE PERSON'S SIGNATURE	DATE
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CLIENT SERVICES TRUST FUND FINANCIAL NEED STATEMENT

CLIENT'S NAME *(Last, First, M.I.)*

INCOME					
HOUSEHOLD INCOME	GROSS MONTHLY INCOME	ALIMONY/CHILD SUPPORT	OTHER <i>(Food Stamps, Public Housing, etc.)</i>	SSI/SSD	TOTAL INCOME
CLIENT:					
OTHERS:					
COMBINED TOTAL					

List names and ages of all persons dependent upon the income in the household.

NAME	AGE	NAME	AGE

EXPENSES	
ITEM	MONTHLY AMOUNT
Mortgage/Rent	
Auto	
Phone	
Utilities	
Food	
Insurance	
Child Care	
Credit Cards	
Other <i>(Alimony, Child Support, etc.)</i>	
Exceptional Costs Associated with Care	
TOTAL EXPENSES	
TOTAL INCOME	
TOTAL DISCRETIONARY FUNDS PER MONTH <i>(Income minus expenses)</i>	

To the best of my knowledge, the above information is accurate.

CLIENT/RESPONSIBLE PERSON'S SIGNATURE	DATE
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MAIL COMPLETED FORM TO: Arizona Department of Economic Security
 Division of Developmental Disabilities
 Client Services Trust Fund Coordinator, Site Code 791A
 P.O. Box 6123
 Phoenix, Arizona 85005-6123