West Virginia Department of Health and Human Resources
BUREAU FOR BEHAVIORAL HEALTH AND HEALTH FACILITIES
UNMET NEEDS GRANT PROPOSALS
FOR FY _____

All requests are confidential

Date of Application: **_____**

Name of Applicant who will use Funds: _____

Name of Service Coordinator, Agency, Phone & Email: _____

_____

Diagnoses: _____ D.O.B __/ ___/ _____ **Age of onset:** ___/___/___

Does the individual have a guardian? ☐ YES ☐ NO **Type of Income**: _____

Medley Class Membership? ☐ YES ☐ NO **Income Amount $** _____

Title XIX Waiver Applicant? ☐ YES ☐ NO

Were other sources of funding, or Medicaid, requested and /or denied: ☐Yes ☐No

Please attach proof of denial.

Please indicate the living arrangements of this consumer: **_____**

☐ **Intellectual Disabilities Unmet Needs:**

Service Requested	Total Amount Requested	Medicaid/Medicare/ Insurance Amount Denied	Supporting Documentation Attachment List
Dental	**$**	**$**	
Medical	**$**	**$**	
Vision	**$**	**$**	
Adaptive Equipment	**$**	**$**	
Home Modification	**$**	**$**	
Speech, OT, PT	**$**	**$**	
Start Up	**$**	**$**	
Other	**$**	**$**	

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Please include narrative for request(s)

Signatures

Team Signature/Date
Consumer/Guardian:
Case Manager Supervisor/MR/DD Waver Contact Person:
Medley Advocate
Team Member
Team Member
Team Member