

**INCIDENTAL EXPENSE  
PRE-AUTHORIZATION FORM**



**CLIENT INFORMATION**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS #:** \_\_\_\_\_  
**Primary Diagnosis:** \_\_\_\_\_ **Secondary Diagnosis:** \_\_\_\_\_

**PROVIDER INFORMATION**

**Provider Name:** \_\_\_\_\_ **Program Name:** \_\_\_\_\_ Care Coordination  Undocumented   
Supportive Housing  Other (Specify):  \_\_\_\_\_  
**Contact Person:** \_\_\_\_\_ **Contact Number:** \_\_\_\_\_ **Contact Email:** \_\_\_\_\_

**REQUEST FOR SERVICE FUNDING**

**Total Amount requested :** \$ \_\_\_\_\_ **# of items/units** \_\_\_\_\_ **Length of Need** \_\_\_\_\_  
(If requesting a service, list rate per hour)

**Procedure Code:** \_\_\_\_\_ **Description of goods/services requested:** \_\_\_\_\_

**General reason for request/benefit to client (Include treatment goal being addressed):** \_\_\_\_\_

**Alternatives explored:** \_\_\_\_\_

Vendor Name	Vendor Address

\_\_\_\_\_  
**Provider Representative Signature**

\_\_\_\_\_  
**Date**

**TO BE COMPLETED BY CENTRAL FLORIDA CARES:**

**Incidental Expense Request:**     Approved     Denied

**Amount Approved:** \$ \_\_\_\_\_ **Authorization Start Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Reason For Denial:** \_\_\_\_\_  
\_\_\_\_\_

**System of Care Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Contract Manager Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**DISCLAIMER:** This Authorization does not guarantee available funds in the subcontractor's contract.