TANF AUTHORIZATION REQUEST FORM

CLIENT INFORMATION

Client's Name: ______________________ **DOB** ____________ **SSN#** ____________

Does Client have Medicaid? ☐ Yes ☐ No

TANF STATUS

TANF Eligibility Number: ____________________ **Date of TANF Eligibility:** ____________

TANF Status: ☐ New ☐ Re-Authorization **TANF Participant Status:** ☐ TCA ☐ TDF ☐ Post TANF

PROVIDER INFORMATION

Provider Name: ______________________ **Date of Request:** ____________

Contact Person: ______________________ **Email:** ____________

REQUESTED SERVICES

Clinical Referral Focus: ☐ Mental Health ☐ Substance Abuse ☐ Dual Diagnosis

Primary Diagnosis: ______________________

		To Be Completed by CFCHS					
Type of Service	**Frequency**	Total Units	X	Rate	=	Total	Procedure Code
					=		
					=		
				TOTAL:	$		

______________________ ______________________

Provider Representative Signature **Date**

Please send request to : Madeline Jarman, TANF Specialist
Fax: (321) 732-7061 Email: MJarman@CFCHS.org

TO BE COMPLETED BY CENTRAL FLORIDA CARES:

Authorization Request: ☐ Approved ☐ Denied

Approval valid from ____________ and expires on ____________

Reason for denial: ______________________

______________________ ______________________

CFCHS TANF Specialist Signature **Date**

______________________ ______________________

CFCHS Qualified Professional Signature **Date**

Revised 2/2015