INCIDENTAL EXPENSE
PRE-AUTHORIZATION FORM

CLIENT INFORMATION

Client Name: _____ **DOB:** _____ **SS #:** _____

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

PROVIDER INFORMATION

Provider Name: _____ **Program Name:** Care Coordination ☐ Supportive Housing ☐ Undocumented ☐ 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.