State of Kansas Department for Children and Families Prevention and Protection Services

Independent Living Subsidy Payment Unit Notification

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☐ Initial Request Date Effective:		☐ Change Date Effective:				☐ Suspend / Terminate Date Effective:		
Youth Name:								
SSN & DOB:								
Address:								
11441455.								
Phone #:								
Email:								
Landlord Name:								
Address:								
Phone #:								
Email:								
Mentor Name	:						□NA	
SSN & DOB:								
Address:								
DI //								
Phone #:								
Email: Will the Mentor be		the sub-	sidy navoa?	Yes	No			
will the Ment	or ne	the sub	sidy payee:	1 es_	110			
Subsidy Amount and Month Authorized:								
Subsidy								
Month & Year								
Amount								
Authorized	\$		\$	\$	\$	\$	\$	
Approval Sign	ature	es:						
Y 1		C				n ·		
Independent L	Coordi	Coordinator (ILC)			Date:			
Independent Living Supervisor Date:								
This form is to be completed and filed with the Eligibility Payment Unit in order for subsidy								
payments to be issued.								

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Eligibility Payment Unit:					
Name of DCF Staff Entering the Subsidy:					
Date the Authorized Subsidy Was Entered Initially,					
Changed, Suspended or Terminated:					
An electronic copy shall be returned to the ILC with the above information completed. The					
ILC shall place a completed copy in the youth's case file.					



Strong Families Make a Strong Kansas