|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Initial Request** | | **Change** | **Suspend / Terminate** | | | |
| **Date Effective:** | | **Date Effective:** | **Date Effective:** | | | |
|  | | | | | | |
| **Young Adult Name:** |  | | | | |
| SSN & DOB: |  | | | | |
| Address: |  | | | | |
| City/State/Zip |  | | | | |
| Phone #: |  | | | | |
| Email: |  | | | | |
|  |  | | | | |
| **Vendor Name:** |  | | | **Vendor ID:** |  |
| Address: |  | | | | |
| City/State/Zip |  | | | | |
| Phone #: |  | | | | |
| Email: |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Subsidy Amount and Month Authorized:** | | | | | | |
| **Month/Year** |  |  |  |  |  |  |
| **Amount Authorized** | $ | $ | $ | $ | $ | $ |

|  |  |
| --- | --- |
| **Approval Signatures:** | |
|  |  |
| **Independent Living Coordinator (ILC)** | **Date** |
|  |  |
| **Independent Living Supervisor** | **Date** |
| *Staffing Notes:* | |
| ***This form is to be completed and submitted to the Eligibility Payment Unit for subsidy payments to be issued.*** | |

|  |  |
| --- | --- |
| **Eligibility Payment Unit:** | |
| Name of DCF staff entering the subsidy payment: |  |
| Date authorized subsidy was entered, changed, suspended, or terminated by Eligibility Payment Unit: |  |
| ***An electronic copy shall be returned to the ILC with the above information completed. The ILC shall place a completed copy in the case file.*** | |