Department of Behavioral Health

Authorization for Issuance of Immediate Need Voucher(s)

FOR INTERNAL USE ONLY

Child/Youth Name (LN, FN)	Date of Birth	Gender	*Ethnicity
	/ /	☐ M ☐ F	C ☐ B ☐ H ☐ A ☐ AI ☐ O ☐
	/ /	☐ M ☐ F	C ☐ B ☐ H ☐ A ☐ AI ☐ O ☐
	/ /	☐ M ☐ F	C ☐ B ☐ H ☐ A ☐ AI ☐ O ☐
	/ /	☐ M ☐ F	C ☐ B ☐ H ☐ A ☐ AI ☐ O ☐

* C = Caucasian, B = Black, H = Hispanic, A = Asian, AI= American Indian, and O = Other

SIMON # (Case #) _____ Parent/Guardian's Name _____

Adult Recipient's Name _____ Recipient's Phone Number _____

Recipient Address _____

Request for Issuance of Voucher: ☐ Deliver to client ☐ Client to pick up

I, _____ (Staff name), authorize to _____
an Immediate Need payment for the above child(ren) for: (Name of Parent/ Guardian/ Relative Custodian)

☐ Item(s)_____
Vendor_____
Address _____ City_____ State_____ Zip_____
Max Amount Issued $_____ Voucher #_____
Cost Per Item $_____

☐ Item(s)_____
Vendor_____
Address _____ City_____ State_____ Zip_____
Max Amount Issued $_____ Voucher #_____
Cost Per Item $_____

☐ Item(s)_____
Vendor_____
Address _____ City_____ State_____ Zip_____
Max Amount Issued $_____ Voucher #_____
Cost Per Item $_____

Justification for issuance is documented in the: _____

_____

Issuance/ Custodian signature Date

Clinician/Social Worker (print) Date

Supervisor Approval signature Date

Clinician/Social Worker signature

Phone ( )

Original: HS Auditing
Copy: Fund Custodian
Copy: Clinician/Social Worker
Copy: HS Admin