



NC DSS Approved Alternative Option

COUNTY: _____

Table with 3 columns: Item, Description (Please include behavioral health diagnosis.), Cost. Multiple empty rows for data entry.

Child's First Initial and Last Name related to this request: _____
Has an EPF request been made for this child before? Yes [] No []

If this request involves placement in an unlicensed setting, has this placement been approved by the court?
Yes [] No []

For unlicensed settings, please include in description the type of unlicensed setting and verification of/reason why Medicaid funds cannot be used for the placement.

Director/Authorized Designee Signature _____ Title _____ Date _____

Date Reviewed by EPF Review Committee: _____

Submission: Approved [] Denied []

Denial Explanation

Empty rectangular box for Denial Explanation.