PECIAL NEEDS APPLICATION											S
001 Applicant last name:	002 Applicant given name(s):	(003 Applicant treaty number:								
				I	I	Ι	I	I	I	I	I
	TYPE OF ASSISTANCE										
Special Needs Requirement			Support Document Required		Allowance paid directly to Vendor			Amount			
140A Special Needs (Non-Insured Health Benefits)								\$			
140B Special Needs (Other)				1							
								\$			
	Transfer to line 140A and or 140B on Budget and a tems and/or services provided: and 4.7 of the regional manual for limitations and						5.	\$			
	tems and/or services provided: and 4.7 of the regional manual for limitations and						5.	\$			
For all claims refer to Section 4.6	ems and/or services provided: and 4.7 of the regional manual for limitations and ON CLIENT FILE WITH RECEIPTS)						5.	\$			
For all claims refer to Section 4.6 (THIS FORM TO BE RETAINED C	ems and/or services provided: and 4.7 of the regional manual for limitations and ON CLIENT FILE WITH RECEIPTS)	d maxin	num	all	owa	nces					
For all claims refer to Section 4.6 (THIS FORM TO BE RETAINED C I have reviewed eligible allowances v Signature of Applicant	tems and/or services provided: and 4.7 of the regional manual for limitations and ON CLIENT FILE WITH RECEIPTS) with the Issuing Authority.	d maxin	num	all	owa	nce					
For all claims refer to Section 4.6 (THIS FORM TO BE RETAINED C I have reviewed eligible allowances v Signature of Applicant	tems and/or services provided: and 4.7 of the regional manual for limitations and DN CLIENT FILE WITH RECEIPTS) with the Issuing Authority.	d maxin	num	all	owa	nce					