

COST SHARING AGREEMENT FOR DUAL DIAGNOSIS INTERVENTION TEAM CASE
MI/MRDD TASK FORCE

Individual's Name _____ D.O.B. _____

Address _____ City _____ Zip _____ Phone _____

Guardian (if applicable) _____ Phone _____

Lead Case Manager _____ Agency _____ Phone _____

Agreement covers these dates: From _____ to _____

SERVICE (Provider, frequency, cost per unit)	TOTAL COST

Date of cost share agreement _____

Sharing agreement total cost \$ _____

FUNDING SOURCE	%	Maximum amount	Approval Signature
MH&RS Board	_____	\$ _____	_____
MR/DD	_____	\$ _____	_____
Other	_____	\$ _____	_____

Local funding agencies' total cost \$ _____

Individual/Guardian participation in Cost Share Agreement \$ _____

Individual/Guardian agrees to reimburse MI/MRDD Task Force _____
(Individual/Guardian signature)