Columbus Area United Way

Voucher Request Form

CFP Community Prevention Mental Health Vouchers for Youth

Please Send Platte, Colfax, Boone or Nance County Referrals (or questions) to:
vouchers@columbusunitedway.com **United Way office**: 402-564-5661

*Not Redeemable for Cash. THE FIRST APPOINTMENT SHOULD BE SCHEDULED WITHIN THREE MONTHS OF THE DATE OF THIS REQUEST. ALL SESSIONS TO BE PROVIDED VIA THIS VOUCHER MUST BE USED WITHIN **SEVEN MONTHS** OF THE REQUEST DATE.*

Date: _____

Name of Youth First: _____ Middle: _____ Last: _____

Date of Birth: _____ **NE Student ID #:** _____

Race (circle): American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander White More Than One Race Other

Ethnicity (circle): Hispanic/Latino Non-Hispanic/Latino Other Ethnicity Reported: _____

Sex Assigned at Birth (circle): Male Female Prefer Not to Answer

Gender: Male Female Non-binary Prefer Not to Answer

Parent/Guardian Name: _____

(As listed on CR Intake forms; THE FORM MUST BE COMPLETED WITH THE PARENT AS THE CLIENT UNLESS 18 YEARS OLD OR OLDER – PLEASE REVIEW TO MAKE SURE ALL QUESTIONS HAVE BEEN ANSWERED AND SIGNED AS APPROPRIATE)

Mental Health Provider (from approved list): _____
(*agency name, not individual counselor*)

Number of sessions requested: _____ (MAXIMUM of 8 can be requested)

Does family have insurance coverage (will be billed first): Yes No

Name of Insurance Company: _____

Amount parent can contribute for each session: _____
Households with insurance must contribute a minimum of $30 per session.

Referral made by (name/organization): _____

CR referral form for coaching submitted (MUST PROVIDE COMMUNITY PREVENTION BROCHURE AND OFFER COACHING TO FAMILY; does not affect Voucher approval if they refuse the service): Yes No

Also Supported by: *Nebraska Children & Families Foundation* *Nebraska Crime Commission*

Updated 11/27//2024

Voucher Request Form
Income Eligibility Information

Income Guidelines

To qualify for assistance through the Youth Mental Health Voucher Program, your income must be less than the amount listed for your household size or have financial need due to unforeseen circumstances (additional medical bills, extended unemployment, etc.)

Household Size	Income Limit
1	$37,650
2	$51,100
3	$64,550
4	$78,000
5	$91,450
6	$104,900
7	$118,350
8	$131,800

Source: U.S. Department of Health and Human Services, Federal Poverty Guidelines – 250% of Poverty Level

Household Information:

Parent/Guardian Name(s): _____

Employer(s) for Parent: _____

Annual Income from Employment: _____

Employer(s) for 2nd Parent in Household: _____

Annual Income from Employment: _____

Child Support (if applicable): _____

Insurance Provider: _____

IF YOUR CHILD IS COVERED BY MEDICAID, IT WILL COVER THE COST OF THE SERVICES AND VOUCHERS SHOULD NOT BE REQUESTED.

Reason for financial assistance request if over income:

_____

_____

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