

**INTENSIVE TECHNICAL ASSISTANCE REQUEST FORM**

Date of Request: \_\_\_\_\_

Person for whom Technical Assistance is being requested (initials only): \_\_\_\_\_

BSU # \_\_\_\_\_

Funding County: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Residing County: \_\_\_\_\_

**Agency Contact Information:**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Supports Coordinator Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_

**Type of Technical Assistance Needed:** *(select one or both)*

Physical Health Condition

Behavioral Health Condition

**Reason for Request:** *(may attach supporting documentation as needed)*

County Coordinator Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Receipt of this request: \_\_\_\_\_

County Coordinator Signature: \_\_\_\_\_ *(If emailing form, please type name)*

Comments:

**\*\*\* Please e-mail the completed form to: [info@hcqu.org](mailto:info@hcqu.org) \*\*\***