CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES

Memo of Justification

Supplement Service Per Diem

To: , Service Region Administrator

From:

Date:

Subject: Memo of Justification for a Supplement Service

Child:

Case number:

Foster family:

Additional household members:

Reason for Supplemental Service Per Diem

Describe in detail the current situation for the child, including a justification describing the necessary finances needed to meet the child's needs. Please include information regarding the child's level of care, serious emotional disability, possible discharge from hospitalization or QRTP, medical complexities, or justice involved youth. Please provide information regarding services provided to the child and plan of care to support the family.