

**DBHDS ID/DD Guardianship Funding Request**

**CSB: Date:**

**CSB Contact:**

**Email Address:**

**Contact Number #:**

**Instruction to CSB:**

1. The individual for whom funding is requested must have been assigned an ID/DD-DBHDS Guardianship slot and approval from the Public Guardianship Program multidisciplinary panel.
2. The request for funding should be the **actual** costs expensed in attorney fees but shall not exceed $2,000 per person.
3. Funds are not guaranteed and are subject to denial if DBHDS allotted funding is expensed.
4. Invoice from attorney should be submitted in their original WORD format via EMAIL to: public.guardianship@dbhds.virginia.gov

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| --- | --- | --- |
| Individual’s Name  | Funding Requested (Not to exceed $2,000 per person) | **Total** |
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| **TOTAL AMOUNT** |  |  |

**Internal use only**

Printed Name: Sheila Snead

Title: Community Program Manager or Designee

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_