



# CACDC Funds



## About

The purpose of the CACDC is to provide one-time financial assistance to individuals with chronic mental health conditions. This assistance is intended to support the provider in resolving a presenting concern while providing immediate stabilization.

## Application

Application can be found on Family Service Agency website.

Case managers, counselors, psychiatrists, and mental health providers may complete an application on **behalf** of their clients. Applications are reviewed by the committee on a schedule and payments and decisions are distributed by Family Service Agency immediately following.

## Funding

**What This Covers:**

- Household Essentials
- Clothing & Shoes
- Hygiene Supplies
- Past Due Rent
- Past Due Utilities
- Other Requests Are Accepted

**What This Does NOT Cover:**

- Medications
- Legal Fees
- Pets and Animals
- Other

## Contact Information

CAP@fsadekalbcounty.org  
www.fsadekalbcounty.org  
P: (815) 758-8616 | F: (815)758-7569

*This program was previously housed within the DeKalb County Community Mental Health Board. CACDC is still entirely funded by DCCMHB but is now within the umbrella of Family Service Agency, specifically the Community Action Program.*

**Consumer Advocacy Council of DeKalb County**

**Request for Funds (7/1/2024 – 6/10/2025)**

*The purpose of the CACDC is to provide one-time financial assistance to individuals living in DeKalb County with chronic and persistent mental health conditions. This assistance is intended to support the case manager, counselor, or provider in resolving a presenting concern while providing immediate stabilization.*

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**Date of Application:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_

**Provider Agency:** \_\_\_\_\_ **Provider Email:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **Client DOB:** \_\_\_\_\_

**Client Address (street, unit, city, zip):** \_\_\_\_\_

**What is being requested (past due rent, clothing, etc.)?** \_\_\_\_\_

**What is the dollar amount being requested?** \_\_\_\_\_

**Has the client received funding from CACDC in the past?**

- Yes  No  Unsure

**Do you attest that this individual has a chronic, persistent mental health diagnosis?**

- Yes  No  Unsure

**Household income sources (earned and non-earned income for all members):**

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**Please include your typed narrative in an attached document or email.**

***Narrative should answer the following questions:***

- How does the need impact the individual's mental health?
- How would an approval of this request impact their mental health, ability to engage in services, household stability, financial well-being, etc.?
- What other resources the individual utilized/attempted to access to resolve this situation?
- Who is in the household, who is contributing to the household income, etc.?
- Who is on the client's care team (specific to mental health and financial well-being)?
- Are there any special circumstances the CACDC Advisory Committee should be aware of to aid them in making an informed decision? (ex: shelter placement, dietary needs, etc.)

## Consumer Advocacy Council of DeKalb County

If requesting **rent** (*rental assistance will be issued directly to the property manager*):

- Landlord/Property Manager Name: \_\_\_\_\_
- Billing Address (street, city, zip): \_\_\_\_\_
- Include copy of rent ledger with request

If requesting **utility** assistance (*utility assistance will be issued directly to the company*):

- Utility Company: \_\_\_\_\_
- Billing Address (street, city, zip): \_\_\_\_\_
- Include copy of utility bill with request

If requesting **vehicle** assistance (*vehicle assistance will be issued directly to lender/shop*):

- Lender (if requesting past due car payment): \_\_\_\_\_
- Mechanic shop (if requesting vehicle repair): \_\_\_\_\_
- Billing Address (street, city, zip): \_\_\_\_\_
- Include copy of active insurance and registration

If requesting clothing, hygiene products, household essentials, etc.:

- List items requested here:  
\_\_\_\_\_  
\_\_\_\_\_
- If approved by the CACDC Advisory Committee, Family Service Agency will communicate with the provider to purchase the requested and approved items

## Process

### Submission:

- Applications must be submitted by a mental health provider, case manager, or counselor. Applications submitted by individuals.
- Illegible applications will not be reviewed.
- The CACDC Advisory Committee reviews applications on the first and third Monday of every month. Applications must be submitted at least three days before the CACDC Advisory Committee meeting to be reviewed.
- Submit complete applications with required documentation to: [CAP@fsadecalbcounty.org](mailto:CAP@fsadecalbcounty.org).

### Approval:

- Family Service Agency will notify the provider of the decision immediately following the CACDC Advisory Committee meeting.
- Funds are contingent upon timely response from the provider. Upon notification of approval, the provider has ten business days to provide all requested documentation and/or information. After ten business days of inadequate response, the allocated funding for the client will be forfeited and a new request must be submitted to the Committee for review.