REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral Health

Opioid Flex Funds Reimbursement Request Form

Requestor Name: _____

Phone: _____ Email: _____

Check Payable to (Provider Agency Only) _____

Address to send check to:_____

Request Date: _____

First and Last Initial and Last 4 Digits of Consumer SS #: _____
County consumer resides in: _____

What gap/barrier did flex funds address: _____

_____

What other resources were explored prior to using flex funds: _____

_____

_____

Please Note: Flex funds cannot exceed $5,000 per consumer per state fiscal year (July 1-June 30).

Amount Requested for reimbursement:

_____

Description – CHECK ALL THAT ARE BEING REQUESTED

Housing ☐One-Time Deposit on Apartment ☐Rent
☐Other Housing ☐Storage Unit ☐ Motel
☐ Campground ☐Temporary Housing

Transportation ☐Bus ☐Gasoline ☐Handi-van
☐Minor Car Repair ☐Taxi ☐Other Transportation

☐ Food (while seeking treatment)
☐Hygiene Items/Self-care
☐Legal Documents
☐ Adaptive Equipment
☐ Other (please list) _____
_____
_____

Requestor Signature: Date:

Authorized By: Date: