



REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral Health

Opioid Remediation Settlement Flex Funds Request Form

This form must be completed and submitted by an agency/organization - no applications will be accepted from consumers.

Please email questions or completed form, W-9 (as applicable), and Eligibility Worksheet for NBHS Funded Services to Trina Janis at tjanis@region5systems.net

Request Date: _____ Agency/Organization Submitting Application: _____

Agency/Organization Contact: _____ Agency/Organization Phone: _____

Agency/Organization Email: _____ Consumer County or Residence: _____

Consumer Name: _____ Last 4 Digits of Consumer SS #: _____

Will the submitter be making purchase(s) and requesting reimbursement via check? Yes No

If no, name of the landlord/business where payment will be made: _____

If payment is to someone other than submitter, will payment be by: Check Credit Card Unknown

What gap/barrier to accessing substance use treatment will flex funds address: _____

What other resources were explored prior to requesting ORS Flex Funds: _____

Please explain the financial situation of the person needing assistance: _____

Attach completed Eligibility Worksheet for NBHS Funded Services

If payment will be made by check and entity receiving payment is not a Region V Systems' Network Provider, attach W-9 for entity receiving payment. Application may be submitted without W-9; however, payment for approved requests may be delayed.

Choose category/categories below and list exact amount requested. Flex funds cannot exceed \$5,000 per consumer per fiscal year (July 1-June 30).

Housing

- One-Time Deposit on Apartment \$_____
 Back Rent \$_____
 Rent _____ (monthly or weekly) X \$_____
 Other Housing _____ (type) \$_____
 Storage Unit _____ (monthly or weekly) X \$_____
 Motel _____ (monthly or weekly) X \$_____
 Campground _____ (monthly or weekly) X \$_____
 Temporary Housing _____ (monthly or weekly) X \$_____

Transportation

- Bus \$_____
 Gasoline \$_____
 Handi-van \$_____
 Minor Car Repair \$_____
 Taxi \$_____
 Other Transportation \$_____

Other

- Food (while seeking treatment away from home) \$_____
 Hygiene Items/Self-care (while in residential treatment only)
 Legal Documents \$_____
 Adaptive Equipment \$_____
 Other (please list item and specific amount) :

Consumer Signature:

Date:

Agency/Organization Signature:

Date: