

PLEASE FILL IN ALL BLANKS

**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***](mailto: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 #: \_\_\_\_\_\_\_\_\_\_\_\_  Consumer Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consumer Gender:\_\_\_\_\_\_\_\_\_ Consumer Age:\_\_\_\_\_\_  Consumer Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the Consumer a Veteran: ☐ Yes ☐ No  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 5 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 in a 12-month period.  **Housing**  ☐ One-Time Deposit on Apartment $\_\_\_\_\_\_\_  ☐ Back Rent $\_\_\_\_\_\_\_  ☐ Rent \_\_\_\_\_\_\_ (months or weeks) X $\_\_\_\_\_\_\_  ☐ Other Housing \_\_\_\_\_\_\_\_\_\_\_ (type) $\_\_\_\_\_\_\_  ☐ Storage Unit \_\_\_\_\_\_\_ (months or weeks) X $\_\_\_\_\_\_\_  ☐ Motel \_\_\_\_\_\_\_ (months or weeks) X $\_\_\_\_\_\_\_  ☐ Campground \_\_\_\_\_\_\_ (months or weeks) X $\_\_\_\_\_\_\_  ☐ Temporary Housing \_\_\_\_\_\_(months or weeks) X $\_\_\_\_\_\_  **Transportation**  ☐ Bus $\_\_\_\_\_\_\_  ☐ Gasoline $\_\_\_\_\_\_\_  ☐ Handi-van $\_\_\_\_\_\_\_  ☐ Minor Car Repair\* $\_\_\_\_\_\_\_  ☐ Taxi $\_\_\_\_\_\_\_  ☐ Other Transportation $\_\_\_\_\_\_\_  *\** *Formal estimate from a car repair shop that has been in business for a minimum of one year is required to verify cost.*  **Other**  ☐ Food (while seeking treatment away from home) $\_\_\_\_\_\_\_  ☐ Hygiene Items/Self-care $\_\_\_\_\_\_\_  (while in residential treatment only)  ☐ Legal Documents $\_\_\_\_\_\_\_  ☐ Adaptive Equipment $\_\_\_\_\_\_\_  ☐ Other – Attach sheet with item description and exact amount. |

Consumer Signature: Date:

Agency/Organization Signature: Date: