

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***

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| 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 ☐ NoWill the submitter be making purchase(s) and requesting reimbursement via check? ☐ Yes ☐ NoIf 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 ☐ UnknownWhat 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: