PLEASE FILL IN ALL BLANKS

REGION 5 SYSTEMS
Supporting Wellness and Recovery in Behavioral Health
SINCE 1974

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 opioid@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:

Updated 8/1/25