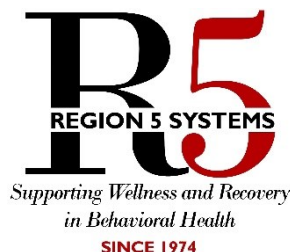


PLEASE FILL IN ALL  
BLANKS



## 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 [opiod@region5systems.net](mailto:opiod@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: