Family Assistance & Social Determinant Funding Request Form

Please fax request to 833-370-8773 or email to FASD@carelon.com

All areas on the form must be completed for processing.
Requests will not be processed without a W-9 form and supporting documentation.
Funding is intended to be paid directly to vendors/providers after services are rendered.

Referral Information			
Referral Source: Family ☐ Behavioral Health Provider ☐ Medical Provider☐ DCF ☐ Other ☐			
Referral Contact Person:		Request Date:	
Agency/Relationship to the Youth/Family the funds will support:			
Email Address:		Phone Number:	
Child Demographic Information	Primary Child Insurance: Choose an item. select one		
Child's Name (First, Last):			Date of Birth:
Street Address			
City:		State:	Zip Code:
		Select	
Primary Language:		Gender:	
Specify:		Select One select one	
Race:		Ethnicity:	
Select One select one		Select One select one	
Child's Current Living Situation			
Current Living Situation:	If Other, please specify:		
Select One select one			
If currently in a treatment facility, Facility Name:			
Facility Street Address:		Facility Phone:	
City:		State:	Zip Code:
		Select	
Facility Contact Person, if applicable:		Phone:	
Parent/Legal Guardian Information			
Primary Parent/Legal Guardian Name:	Relation to the child:		
Street Address:	***If the same as the child's address check here:*** ☐		
City:	State:		Zip Code:
Primary Phone:	Other Phone:		
Primary Language:	Specify preferred language:		

Reason for Referral

Select ONE primary reason for referral:

☐ 1. **BH Treatment Fund**-family has sought and been denied coverage or reimbursement for drug or BH treatment or such intensive services by the family's health carrier AND family is unable to bear the cost of the intervention due to financial hardship

Select all that apply:

☐Intensive in-home or IOP ☐Cost of prescribed psychotropic medications

☐Denial of coverage or reimbursement from insurance carrier ☐Exhausted benefit through insurance carrier

Or

☐ 2. **Social Determinants Fund**-family has sought but cannot access behavioral health treatment and intervention for their child(ren) aged 0 to 18 due to social determinant of health factors AND family is unable to bear the cost of the intervention due to financial hardship and all other means of financial coverage through insurance or community-based resources has been denied.

Select all that apply:

☐discrimination ☐poverty ☐housing or food insecurity ☐unemployment or underemployment

☐adverse early life experiences ☐low educational attainment ☐poor educational quality ☐educational inequality

☐income inequality and living in socioeconomically deprived neighborhood ☐food insecurity

☐poor housing quality and housing instability ☐impact of climate change

☐adverse features of the structures and systems in which family lives/works and poor access to healthcare

Additional Referral Information:

Funding Request Information (may request for services rendered up to 120 days prior)					
Invoice Number:					
Service Start Date	Service End Date	Brief Service Description	# of Units	Cost Per Unit	Total Cost
				Click or tap here to enter text.	Click or tap here to enter text.
Vendor Information					
Vendor Name					
Street Address					
City, State, Zip Code					
Phone Number	.				
Is W-9 Form Attached- The request will not be processed without W-9 Forms				Yes ☐ No ☐	
Is the supporting documentation attached (i.e. invoice)- The request will not be processed without this supporting documentation.				Yes ☐ No ☐	
Please note checks get directly mailed to the vendor **Additional Information for mailing:**					

Please check all the below if you, as the referral source, are in agreement to have this request processed. If you are not in agreement with the below statements, your request cannot be processed.

☐ The family (or self) consents to apply for these funds.

☐ The family (or self) is willing to release Personal Health Information within this request form to Carelon Behavioral Health.

☐ The family consents to have Carelon release payment to the Vendor listed in this request form.

☐ The family attests to having exhausted all other means to financially support the appropriate intervention.

Office Use Only:

Date Received Completed Referral	Date Processed for Payment	Assigned Processing Number
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap here to enter text.