**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: Behavioral Health Provider Medical Provider DCF  Other** | | | | | | |
| Referral Contact Person: | | | | Request Date: | | |
|  | | | | **Click or tap to enter a date.** | | |
| Agency/Relationship to the Youth/Family the funds will support: | | | | | | |
|  | | | | | | |
| Email Address: | | | | Phone Number: | | |
|  | | | |  | | |
| **Child Demographic Information** | | Primary Child Insurance:Choose an item. | | | | |
| Child’s Name (First, Last): | | | | | Date of Birth: | |
|  | | | | |  | |
| Street Address | | | | | | |
|  | | | | | | |
| City: | | | State: | | Zip Code: | |
|  | | | Select | |  | |
| Primary Language: | | | Gender: | | | |
| Specify: | | | Select One | | | |
| Race: | | | Ethnicity: | | | |
| Select One | | | Select One | | | |
| **Child’s Current Living Situation** | | | | | | |
| Current Living Situation: | | If Other, please specify: | | | | |
| 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** | | | | | |
| Service Start Date | Service End Date | Brief Service Description | # of Units | Cost Per Unit | Total Cost |
|  |  |  |  |  |  |
| **Vendor Information** | | | | | |
| Vendor Name | |  | | | |
| Street Address | |  | | | |
| City, State, Zip Code | |  | | | |
| Phone Number | |  | | | |
| **Is W-9 Form Attached- Request will not be processed without W-9 Forms** | | | | Yes  No | |
| **Is the supporting documentation attached (i.e. invoice)- 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.**

I attest that I communicated with the parent /guardian and received consent to apply for these funds.

I attest the parent 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 |
|  |  |  |