Alliance Use Only

Check #

Check Date

Cashed on

Verified by:

*Please submit a typed request*

Total Amount of check:

County:

**Adult Flex Funds Request Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Adult |  | Care Review date (if applicable)  |  |
|  Date of Birth |  | Agency Contact Name  |  |
| Guardians (if applicable) |  | Agency Name |  |
| Phone Number |  | Agency Contact Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Item being Requested & Total Cost of Service/Goods |  | Vendor Name (this is the name of the agency that the check will be mailed to) |  |
| Individual/Family Contribution**\*\*** |  | Vendor Address |  |
| Community Partner Contribution**\*\*** |  | City, State, Zip |  |
| Total Amount of Flex Funds being requested |  | Vendor Phone Number |  |
| Revised PCP, ISP, or outpatient treatment plan uploaded into Alpha(Yes or No)  |  | Vendor Contact Person’s Name  |  |
| Is vendor willing to accept check from Alliance? Yes or no |  | Is vendor’s valid W-9 and Vendor Form attached to request? (both forms are required) |  |

1. **Whenever possible, the proposal should include contributions from the individual/family and community partner(s). If contributions are not included, please explain why:**
2. **Reason for Request (please include (1) how the service/goods being requested will help meet the service needs of the individual and (2) what other revenue sources were considered, pursued, and ruled out):**

**APPROVAL:**

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Referral Source Date Individual/Legal Guardian Date

Alliance System of Care Coordinator Date Community Engagement Manager Date