ADHS / DBHS PM FORM 3.13.1
SAPT/CMHS FLEX FUND REQUEST

Client Name:		**Date:**	
CIS ID:		**Date of Birth:**	
Request Completed By (Name/Title)			
Provider Name:			
TRBHA Name:			

Type of funds requested:[1]	[ ] SAPT [ ] CMHS	
Amount requested:	$	
Goods or Services to be purchased:	1.	3.
	2.	4.
Describe how the use of funds relates to the service plan:		
Describe all other avenues of funding that have been explored to meet this need:		
1.		
2.		
3.		
4.		
Payment will be made to:		
In the amount of:		
Client's total year to date flex fund expenditure:		

ALL REQUESTS MUST MEET THE FOLLOWING CONDITIONS:

1. All other avenues of funding for the goods/services requested must have been explored and documented above.
2. The purchase must be directly related to the service plan and the service plan must accompany this document.
3. Receipts must be tracked for all purchases per DBHS policy.
4. Flex funds may not be used to make cash payments to clients.
5. All flex funds must be used in accordance with DBHS Provider Manual 3.13 and comply with Federal Block Grant requirements.

Authorizations		
_____ Requesting Provider Staff Member (print)	_____ Signature	_____ Date
_____ Supervisor (print)	_____ Signature	_____ Date
_____ RBHA Representative (print)	_____ Signature	_____ Date
_____ ADHS/DBHS Representative (print)[2]	_____ Signature	_____ Date

[1] Member must meet criteria for SAPT or CMHS services. Please see Provider Manual Section 3.19.

[2] Prior approval by ADHS/DBHS is required for any flex fund utilization in excess of $1,525 per member per contract year.