



# York/Adams HealthChoices Flexible Fund Program Application/Referral Form

County of Residence:  York  Adams

Name of Applicant: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

If Applicant is child/adolescent, please list parent/guardian name: \_\_\_\_\_

Phone Number: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

### Section I. – MA Eligibility/HealthChoices Enrollment:

Enrolled under HealthChoices – Please provide Medical Assistance #

Pursuing MA (Please explain status of MA eligibility): \_\_\_\_\_

Section II. – Amount of Request: \$ \_\_\_\_\_

### Section III. – Purpose of Flex Funds (Please be SPECIFIC):

For what purpose are funds being requested (*i.e., rent, security deposits, utilities, medications, etc.*)? Please elaborate on the circumstances leading up to this request.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If request is for an **upcoming** expense, when is payment due? \_\_\_\_\_

If request is for a **past due** expense, please explain in detail why expense is over due and for how long: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Section IV. – Other Community Resources Explored:

For this request to be considered, please describe what other community resources have been explored and exhausted in obtaining financial support. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section V. – Expected Outcomes:**

How will Flex Funds assist in maintaining the applicant in the community (*or least restrictive environment*) and/or out of higher levels of behavioral health treatment? In order for this request to be considered, there must be clear evidence of a behavioral health connection to the need for Flex Funds.

**Please be as detailed as possible in describing the following points:**

- Applicant’s current behavioral health services receive;
- Symptoms experienced related to the need for Funds;
- History of mental health treatment; and
- Specific treatment that will be avoided if flex funds are utilized?

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**Section VI. – Applicant/Family’s Financial Sustainability:**

Since Flex Funds are considered a one-time only grant; if this request is for an ongoing expense (such as rent, utilities, medications, etc) please describe how applicant will **sustain** these expenses in the future: \_\_\_\_\_

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**Section VII. – Payee of Flex Funds:**

**To whom should these funds be paid? (Money will not be paid directly to consumers or families.)**

Vendor Name (and Contact Person): \_\_\_\_\_

Vendor Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

Account Number (*if Applicable*): \_\_\_\_\_

**Note to Referral Source:** Please remember to obtain a **completed W9 form from the vendor**. You may choose to wait until the HealthChoices’ final decision before obtaining this form; however, once a request is approved, it cannot be processed until the HealthChoices Program receives the completed W9.

**Section VIII. – Referral Source (i.e., Case worker’s contact information):**

Referral’s Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_



# YORK COUNTY HUMAN SERVICES DEPARTMENTS INFORMATION RELEASE FORM

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Children/Youth Services  | <input type="checkbox"/> Community Service                        |
| <input type="checkbox"/> HealthChoices        | <input type="checkbox"/> Youth Development Center | <input type="checkbox"/> Human Services Department                |
| <input type="checkbox"/> Drug/Alcohol Program | <input type="checkbox"/> Veterans Affairs         | <input type="checkbox"/> Mental Health/Mental Retardation Program |

I hereby authorize (Name of Referral Source) \_\_\_\_\_ to release information to  
and/or receive information from **HealthChoices Management Unit** regarding the record of:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The information released will be limited to the following: **The clinical and financial information needed for the purposes of making a decision on any Flexible Fund Application.**

The information will be used for the following purpose(s): **For determining Flexible Fund eligibility.**

This release is valid from (start) \_\_\_\_\_ to (end) \_\_\_\_\_ and may be revoked at any time, except to the extent that action has already been taken based on this authorization. To revoke this authorization, please notify, in writing, the York County Human Services Agency identified above. I understand that I need not consent to the release of this information. However, I choose to do so voluntarily. I understand that treatment, payment, enrollment or eligibility are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services. I understand that there may be a risk that the person/organization receiving my information could possibly re-disclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I understand what it means.

\_\_\_\_\_  
Signature of client/parent/guardian (Relationship) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Staff Person \_\_\_\_\_ Date \_\_\_\_\_

### VERBAL RELEASE INFORMATION:

*This section is to be used for clients who are unable to provide a signature.*

We have witnessed that the client understands the nature of this release and has freely given his/her consent.

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

**Notice to the recipient of these records:** This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.

**Please provide a copy of the signed release to the individual requesting the release.**



## YORK COUNTY HUMAN SERVICES DEPARTMENTS INFORMATION RELEASE FORM

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Children/Youth Services  | <input type="checkbox"/> Community Service                        |
| <input type="checkbox"/> HealthChoices        | <input type="checkbox"/> Youth Development Center | <input type="checkbox"/> Human Services Department                |
| <input type="checkbox"/> Drug/Alcohol Program | <input type="checkbox"/> Veterans Affairs         | <input type="checkbox"/> Mental Health/Mental Retardation Program |

I hereby authorize **HealthChoices Management Unit** to release information to and/or receive information from

(Name of Vendor/Payee) \_\_\_\_\_ regarding the record of:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The information released will be limited to the following: **Verification of payment for requested service or support under the HealthChoices Flexible Funds program.**

The information will be used for the following purpose(s): **Confirming the need for the requested payment and verification of billing information.**

This release is valid from (start) \_\_\_\_\_ to (end) \_\_\_\_\_ and may be revoked at any time, except to the extent that action has already been taken based on this authorization. To revoke this authorization, please notify, in writing, the York County Human Services Agency identified above. I understand that I need not consent to the release of this information. However, I choose to do so voluntarily. I understand that treatment, payment, enrollment or eligibility are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services. I understand that there may be a risk that the person/organization receiving my information could possibly re-disclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I understand what it means.

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Signature of client/parent/guardian      (Relationship)      Date

\_\_\_\_\_  
Signature of Staff Person      Date

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**Flex Fund Application (attachment)  
Financial Resource Evaluation Worksheet**

**Please complete worksheet with MONTHLY Average Costs**

**Applicant's Name:**

**# of People Living in Household:**

**Date Completed:**

| <b>MONTHLY Income and Expenses:</b>     |  | <b>Asset Evaluation</b>                   |  |
|---|--|---|--|
| <b>Income (family)</b>                  |  | Savings                                   |  |
| Earnings (net)                          |  | Investments                               |  |
| SSI                                     |  | Capital Equity (net)                      |  |
| SSDI                                    |  | Total Assets                              |  |
| Child Support                           |  | <b>Total Assets Available to Utilize:</b> |  |
| Food Stamps                             |  |   |  |
| Other                                   |  |   |  |
| <b>Total Income</b>                     |  |   |  |
|   |  |   |  |
| <b>Expenses</b>                         |  |   |  |
| Rent/Mortgage                           |  |   |  |
| Real Estate Taxes                       |  |   |  |
| Utility Gas                             |  |   |  |
| Utility Electric                        |  |   |  |
| Utility Water                           |  |   |  |
| Utility Telephone                       |  |   |  |
| Utility Cable TV                        |  |   |  |
| Utility Internet Services               |  |   |  |
| Utility - Sewer, trash collection, etc. |  |   |  |
| Clothing                                |  |   |  |
| Food/Groceries                          |  |   |  |
| Auto payment (# of vehicles _____)      |  |   |  |
| Auto repairs/maintenance                |  |   |  |
| Auto insurance                          |  |   |  |
| Auto - gas                              |  |   |  |
| Insurances (other)                      |  |   |  |
| Medications / health care               |  |   |  |
| Credit card (consumer debt pay)         |  |   |  |
| Entertainment Expenses                  |  |   |  |
| Other expenses: Please specify...       |  |   |  |
|   |  |   |  |
|   |  |   |  |
|   |  |   |  |
|   |  |   |  |
| <b>Total Expenses:</b>                  |  |   |  |
|   |  |   |  |
| <b>Total Income minus Expenses:</b>     |  |   |  |

**Additional Comments:**

**York/Adams HealthChoices Flexible Fund Program  
Participant Agreement**

**Please read and sign if Request is for Fixed Assets:**

I/We agree to participate in the HealthChoices Flexible Funds Program.

I/We understand that all purchases and/or services **must** be prior approved by the HealthChoices Management Unit and will be paid directly to the vendor in most cases.

**I/We understand that any items purchased with the Flexible Funds are the property of the York/Adams HealthChoices Management Program and may not be sold or transferred without the written permission from the York/Adams HealthChoices Management Program. The York/Adams HealthChoices Management Program may require the return of any unused supplies or equipment when the purpose for which the supplies were purchased has expired. Return of any property is the responsibility of the consumer/family.**

\_\_\_\_\_  
Signature of Consumer/Family Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of HealthChoices Management Unit

\_\_\_\_\_  
Date