carelon
Behavioral Health

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

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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: Click or tap here to enter text.

Funding Request Information					
Service Start Date	Service End Date	Brief Service Description	# of Units	Cost Per Unit	Total Cost
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Vendor Information		
Vendor Name	Click or tap here to enter text.	
Street Address	Click or tap here to enter text.	
City, State, Zip Code	Click or tap here to enter text.	
Phone Number	Click or tap here to enter text.	
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:** Click or tap here to enter text.		

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.