Kansas System of Care Flex Funds Request Form

Youth Name:
SOC Consumer ID:
DOB:
Address:
City, State & Zip Code:
Phone Number:

Request Date:
Medicaid ID:
MCO:
Other Payer Source:
CMHC:
Date Enrolled in SOC:

Parent/Legal Guardian Name (if applicable):
Phone Number:

Amount Requested:
Date Needed:
Purpose of Flex Funds Request:

Answer the following and attach all documentation to support this request:

- Has the family received flex funds before? If yes, include the reason and date:

- Is the youth covered under a Foster Care, Adoption, or Family Preservation Contract? If yes, who is the contractor?

- Describe the youth's history of hospitalizations/out of home placements. What is their current risk of hospitalization or placement?

- Describe the treatment goals and objectives and how the flex funds support the treatment plan:

- Describe what other funding sources have been explored and the outcome of each request (including donations). At least two other funding sources must have been explored:

- Describe how the youth/family can contribute to the request, if at all:

- Describe the plan for how the family will obtain these services/supports/resources in the future:

Kansas Department for Aging and Disability Services

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
ATTN: SOC PROJECT DIRECTOR
503 S KANSAS AVE., TOPEKA, KS 66603
OFFICE: (785) 296-4736 CELL: (785) 596-3120
EMAIL: KDADS.SYSTEMOFCARE@KS.GOV

System of Care Kansas

SIGNATURES

Youth:

Print Name	Signature	Date

Parent/Legal Guardian (if applicable):

Print Name	Signature	Date

Site SOC Project Coordinator (or proxy):

Print Name	Signature	Date

APPROVALS

Approval is indicated by signing the designated line below. Signature certifies that you have reviewed all documentation and that this flex funds request is directly connected to a therapeutic goal of the individual plan of care and that documentation to support this request is included in the individual's service record.

Site CBS Director (or proxy):

Print Name	Signature	Date

----------Send to KDADS for Approval----------

Approval is indicated by signing the designated line below. Signature certifies that you have reviewed all documentation and authorize the use of Kansas System of Care Flex Funds.

SOC Project Director (or proxy):

Print Name	Signature	Date

SOC Principal Investigator (or proxy):

Print Name	Signature	Date

If not approved, describe reason and recommendations:

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