

(Flex Funds, Loans, Etc) DATE: _____

CLIENT ID# _____ Service Category _____ DOB: _____

CLIENT NAME: _____ Telephone Number: _____

ADDRESS: _____

AMOUNT REQUESTED: \$ _____ Item Purchased: _____ Date Funds Needed: _____

BRIEFLY DESCRIBE CLINICAL NEED FOR FUNDS: _____

IF EXPENSE MEETS DEFINITION OF MEDICALLY NECESSARY:

Clinician's initials confirming Flex request covered in current service plan or (care plan for PH clients)

OR

Clinician's initials confirming PNOTE dated _____ amends service plan for a one time Flex request

NOTE: COUNTY POLICY PROHIBITS DISBURSEMENT OF FUNDS TO CLIENTS W/O DIRECTOR APPROVAL

*******PAY TO THE ORDER OF*****THIS FIELD IS REQUIRED*******

NAME: _____ TAX ID# OR "ON FILE" _____
(NOT NEEDED WHEN USING THE PURCHASE CARD)

ADDRESS: _____ PHONE: _____

If you need assistance with the SSN/Tax ID portion please contact Accounts Payable Clerk, Camille Tanaka at ext. 4815

*******CIRCLE APPROPRIATE USE OF FLEX FUNDS*******

Mac Adult BH 174-P120	Adult Recovery Court 174-P163	CSS 073-P119	Supported/Supportive Housing 173-P124	AID & ASSIST 174-P120	PCIT 075-P122
Medication Assisted Tx 174-P128	ECF/RTF 172-P137	ACT/CSA 073-P131	TTRS 173-P166	Nurse Family Partnership 070-H006	Indigent Acute Care 079-P129
CAT/COS/Crim Justice 174-130	OASIS 172-P139	Mac Family & Youth OP BH 075-P122		Choice Model (AMHI) 073-P119	Rental Assistance (RAP) 173-P136
Peer Assisted Crisis - PAC House 174-P132	ECOS/BSS 172-P140	Family & Youth Crisis/Reach 075-P132	DD Case Management 071-P148	Veterans 071-P115	OABHS Grant 172-P140
Newberg Adult BH 174-142	Maternal Child Health 070-H005	Newberg Family & Youth OP BH 075-P152			

CLIENT LOAN USE ONLY

On _____, I acknowledge receipt of a \$ _____ loan from Yamhill County Health & Human Services. I understand that the loan is to be paid back in full by _____. If I cannot repay the loan by that date, I will discuss the matter with my Case Manager, _____, and make further arrangements for payment. I will pay \$ _____/month until my loan is paid in full.

Client Signature _____ Date _____

*******AUTHORIZATION*******

STAFF REQUESTING
PAYMENT: _____ SIGNATURE: _____ DATE: _____

*******NO SUPERVISOR SIGNATURE REQUIRED FOR REQUESTS UNDER \$100 (Unless otherwise instructed by supervisor)*******

APPROVED BY PROGRAM MANAGER OR SUPERVISOR:* _____ DATE: _____

****Supervisor is attesting that ALL CAPS fields are complete and that clinical documentation of the need exists.***

FOR BUSINESS SERVICES ONLY

General Funds 699.07	OR	YCCO Funds 699.14	Grant Funds 611.30
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|--|---|-------------------------------------|
| <input type="checkbox"/> Entered into Acctg/Flex | <input type="checkbox"/> Expense Report | <input type="checkbox"/> Petty Cash |
| <input type="checkbox"/> Entered into Raintree / Juniper | <input type="checkbox"/> Check Request | <input type="checkbox"/> Charge |
| <input type="checkbox"/> Entered into Loan Management Book | <input type="checkbox"/> Purchase Card | |

**** Please note the Central Accounting Department requires a W-9 form to be completed for all Payees. To ensure timely issuance of flex fund requests, W-9 forms should be included with the initial form if at all possible. If you are unable to get the W-9 form or are unsure of the procedure, the accounts payable clerk can assist you. Please be aware that procurement of the W-9's can delay the payment process. Copies of the W-9 form are available on the Intranet as well as with the Accounts Payable Clerk.**