Magellan HEALTHCARE®

Idaho Behavioral Health Plan
Flex Funds Request Form

Request Type			
Date of Request:			
Urgent? (standard timeline for review would seriously put the member's behavioral health and safety at risk)		Yes ☐ No ☐	
Is this a request for repayment? (If yes, please remember to include itemized receipts)		Yes ☐ No ☐	
☐ By checking this box, I attest that any required documents are included with this request.			

Member Information			
Last Name:		**First Name:**	
Member ID:		**DOB:**	
At risk of homelessness?	Yes ☐ No ☐		
DSM-5 Diagnosis (if known):			

Requesting Party Information			
Name of Requestor:			
Requestor Organization Name:			
Requestor's Phone #:		**Fax #**	
Requestor's Email Address:			

IBHP Flex Funds Request Form

Request Details and Information					
A separate form must be sent for each item or service.					
Date Needed:		**Quantity Needed:**		**Estimated Cost:**	
Item or Service Requested:					
Item Details (for example, product name)**:**					
Requestor's Phone #:		**Fax #**			
Requestor's Email Address:					
Who needs to be contacted regarding this request:				Requestor: ☐ Member/Representative:	
Vendor/Payee:					
Vendor/Payee Phone #:		**Vendor/Payee Email:**			
Please Attach a Vendor/Payee W-9					
Category (Select One):					
☐ **Training/Education**		☐ **Transportation**		☐ **Support Activities**	
☐ **Housing Supports**		☐ **Home/Living Environment**		☐ **Food/Social Supports**	

IBHP Flex Funds Request Form

The Requesting Party acknowledges the use of these Flex funds as a last resort option.
Attach any documentation that supports the pursuit of community or 3rd party resource(s).
Please note, a Budget Worksheet may be requested at a later date. If requested, it's available on the Magellan of Idaho website. Welcome to Magellan Healthcare of Idaho | Magellan Healthcare

What other sources of funding did you try to access? What was the outcome? If not, please explain why:

What is the member's care/treatment plan? How does this item/service connect to the treatment/care plan goals? Please describe how this will support the member's goals.

What is the plan for ongoing funding/supports? Please explain how other ongoing funding/supports will meet the member's needs long term. (If the item is a one-off like an air conditioner you can note that here. If it is a request for something that involves ongoing costs, how will the member transition to using another funding source? If it is an extension, what has changed?)

Requestor (member of the team that is primarily responsible for the care plan that the request is related to):

Requestor Name (printed): _____

Requestor Signature: _____

Please submit completed forms to: IBHPFlexFunds@magellanhealth.com

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