



FINANCIAL ASSISTANCE PROGRAM APPLICATION INSTRUCTIONS

OVERVIEW AND PURPOSE

The Miami County Mental Health Initiative (MHI) is a program started by Miami County community partners to improve community well-being and productivity. Part of this includes funding to help care for county residents who are experiencing, or at risk of experiencing, opioid use disorder, co-occurring substance abuse and related mental health conditions. The funding is part of an overall effort to provide supplemental support for opioid treatment, recovery and prevention. Our aim is to strengthen wrap-around care and coordinated support for recovery by: (a) helping to get residents and their families get back on their feet, and (b) making prevention and recovery programs more effective and longer lasting.

ELIGIBILITY CRITERIA

Eligibility is based on the need for assistance to help with opioid treatment and recovery. Applicants must meet at least *one* of the following criteria:

- Applicant currently resides in Miami County, Kansas (this includes being incarcerated at the Miami County Jail);
- Applicant (or plans to) receives support services from an organization located within Miami County and aligned with MHI's wellness goals and services;
- Applicant's sponsor works for an organization that: i) is located within Miami County, Kansas; and/or ii) serves residents of Miami County, Kansas.

The MHI is committed to fair and equal treatment of all individuals. Applicants will not be denied funding based on race, color, religion, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

SUBMIT APPLICATIONS TO:

The Miami County Health Department:

1. Email: mchd@miamicountyks.org

Subject Line: Financial Assistance Application

2. U.S. Mail or Fax:

Miami County Health Department

1201 Lakemary Drive

Paola, KS 66071

Fax: (913) 294-9506

Attn: Shannon Gaboni, Care Resource Coordinator

3. For drop-off/hand delivery please call

Shannon Gaboni, Care Resource Coordinator

at (913) 294-2431.

EXAMPLES OF REQUESTS THAT WILL BE CONSIDERED FOR FUNDING

- Transportation services
- Assessment, screening and/or treatment
- Emergency or recovery housing
- Medical, dental or prescription coverage

APPLICATION AND NOTIFICATION PROCESS

Prior approval is required for all funding requests, as some funding (e.g., assessments and treatment) may require an agreement with a service provider and/or provider reporting obligations if funded through a grant. It is preferred that prospective recipients be referred by a sponsoring agency or organization and submit an application for funding before approval. All applications and supporting information will be kept confidential.

Applicants will receive notification of approval or denial by telephone or email within five business days of submission. Emergency funding requests under \$200.00 may be decided within one business day. Funding is intended for services related to treatment and/or recovery needs, which include various physical and emotional support services for effective recovery. Financial need is determined by MHI representatives based on application details and sponsor information.

All funding decisions are final. Funding may be terminated without prior notice based upon funding source agreements and limitations. Approval is not guaranteed until written notification to the applicant.

To sustain the program, recipients of Financial Assistance Program Funds are encouraged, when feasible and without causing financial hardship, to donate back into the program at a future date. Donation is optional and not required to receive funding.



FINANCIAL ASSISTANCE PROGRAM APPLICATION

Application Date: _____

Total Amount Requested: _____

Applicant Name: _____ Date Of Birth: _____

Phone Number: _____ Alt. Phone Number: _____ Email: _____

Street Address: _____ Apartment/Suite: _____

City: _____ County: _____ State: _____ Zip: _____

Referred by: _____

(Referring organization/agency and name of person verifying economic need, if applicable)

Brief Description of Request:

Have all other sources of funding been explored/expended? Please provide details below:

Funding Request (Check all that apply):

- Transportation Services (e.g. medical, behavioral health, pharmacy, community supervision, grocery store, etc.)
- Assessment, Screening or Treatment (e.g. behavioral health, alcohol/substance use, batterers intervention, other)
- Emergency and/or Recovery Housing
- Medical, dental or prescription (including MAT) co-pay and/or coverage
- Other (comprehensive wrap-around services for individuals and families)

There are programs to help residents with health-related needs, but they aren't reaching everyone who may need them. Are there things that you/the applicant need help with?

1. Within the past 12 months, have you worried that your food would run out before you were able to buy more?
Yes No Not Applicable
2. Do you ever eat less than you feel like you should because there is not enough food for either you and/or your household?
Yes No Not Applicable
3. Are you interested in receiving mental health services?
Yes No Not Applicable
4. If you are interested, do you prefer in-person or virtual appointments?
In-Person Virtual Not Applicable
5. In the past month, did poor physical or mental health prevent you from doing your usual activities, like work, school or a hobby? Yes No Not Applicable
6. Within the past 12 months, has there been a time when you needed to visit the doctor, dentist, mental health professional, etc., but you didn't because you were worried about the cost? Yes No Not Applicable
7. Do you currently have insurance coverage? Yes No Not Applicable Unknown
8. Do you have a job or another source of steady income? Yes No Not Applicable
9. Do you have stable housing? Yes No Not Applicable
10. Are you worried about losing your housing? Yes No Not Applicable

- 11. Within the past 12 months, have you or your household members been unable to get utilities (heat, water, electricity) when it was needed? Yes No Not Applicable
- 12. Within the past 12 months, has a lack of reliable or affordable transportation kept you from necessary appointments, getting to work, school or from getting things that you need (groceries, medications, etc.)? Yes No Not Applicable
- 13. Do you have enough household supplies (clothing, shoes, blankets, diapers, wipes, toothpaste, hygiene products, shampoo, etc.) Yes No Not Applicable
- 14. Do you feel physically and emotionally safe where you currently live? Yes No Sometimes
- 15. Would you like to receive assistance for any needs identified, marked with a "Yes" above? Yes No
- 16. Are any of the above needs urgent? Yes No

If there are urgent needs, please explain:

I hereby certify that the above information is true and correct to the best of my knowledge.

Applicant Name (printed)

Date

Applicant Signature

This attestation is used for the program to document that the client has no other way to pay for the emergency funding requested. This sponsorship/attestation is required for the MHI Financial Assistance Program.

I, _____, (Applicant Sponsor) attest that I have explored all other payment options and acknowledge that MHI Financial Assistance Program is the last resort funding for this applicant.

Applicant Sponsor Name (printed)

Date

Applicant Sponsor Signature

Sponsor Agency/Organization (if applicable)

Form of Payment Requested by Sponsor (if providing services requested) (Check one):

Credit card purchase (in-person/over the phone; an itemized receipt must be provided)

Voucher/Reimbursement (W-9 must be provided, tax exemption applied (if applicable), itemized receipt must be provided, and a mailed check payment will be issued within 30 days of services rendered)

For Miami County Health Department Staff Use

Date Application Received: _____

Date Application Processed: _____

Application Status: Approved Denied

If denied, detail here: _____

Notification Date: _____

Date Invoice Received: _____

From whom: _____

Date Invoice Processed: _____

Method of Payment: Credit Card Check

Notes: _____