Announcing the Family Assistance & Social Determinant Fund

Providers!

Do you know a family that needs financial assistance to pay for mental health and/or substance use intervention, treatment, or medication for their child(ren) ages 0-18?

For a limited time, funding assistance is available for those that qualify*.
Completed referrals can be sent to:
The Family Assistance & Social Determinant Fund
FAX: 833-370-8773 or E-mail to FASD@carelon.com

Funding may be accessed for services rendered for a child, ages 0 up to 18, needing:

- ✓ Mental health and/or substance use treatment or prescribed medications
- ✓ Adolescent psychiatric services, intensive in-home or intensive outpatient or other recommended community-based service

AND

The family has been unable to access that care because:

- ✓ The family has sought but been denied coverage or reimbursement by their health carrier or have exhausted their benefits,
- ✓ The family is unable to bear the cost of the intervention due to financial hardship.
- ✓ The family has encountered barriers based on social determinants of health such as discrimination, poverty, housing or food insecurity, unemployment/underemployment, adverse early life experiences, or other social determinants related to mental health.

QUESTIONS? Contact Carelon Behavioral Health at: FASD@carelon.com

*Funds are made available for a limited time by the CT Department of Children and Families through the American Recovery Plan Act

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

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:

Funding Request Information					
Service Start Date	Service End Date	Brief Service Description	# of Units	Cost Per Unit	Total Cost
Vendor Information					
Vendor Name					
Street Address					
City, State, Zip Code					
Phone Number					
Is W-9 Form Attached- Request will not be processed without W-9 Forms				Yes ☐ No ☐	
Is the supporting documentation attached (i.e. invoice)- Request will not be processed without this supporting documentation				Yes ☐ No ☐	
Please note checks get directly mailed to the vendor **Additional Information for mailing:**					

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.

☐ I attest that I communicated with the parent /guardian and received consent to apply for these funds.

☐ I attest the parent 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