**HOW TO APPLY TO THE YAMHA FLEXI FUND**

**PURPOSE**

To reduce barriers that prevent 13-18-year-olds affected by mild to moderate mental health or alcohol /addiction issues from accessing necessary services by providing interventions to improve their wellbeing.

**APPLICANTS**

Members of YAMHA are eligible to apply to the FlexiFund on behalf of their clients. The clients must be eligible for publicly funded health services in New Zealand.

**APPLICATIONS**

* must relate to a specific one-off purchase
* must be for funding which is unavailable elsewhere (e.g. family, WINZ)
* may relate to the provision of group work for eligible clients
* funding for individual clients has a recommended cap of $500 +gst
* must include evidence for the amount requested

**SUBMITTING AN APPLICATION**

* **Email completed applications to:** flexifund@odysseychch.org.nz
* incomplete applications will not be considered
* decisions of the CYMHS Clinical Coordinator are final
* it is the responsibility of the applicant to implement the intervention for their client
* payments are made either to the retailer or to the applicant (not to the client) upon presentation of a valid tax invoice or receipt
* all flexifund payments must be complete within 3 months of the approval date
* the applicant is requested to provide a brief narrative of how the funding benefitted their client

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| **How will this benefit your Client?** *If exceeding $500 please note extenuating circumstances* |

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| **CLIENT DETAILS** |
| Name:  | Address:  |
| NHI:  | DoB:  | Ethnicity:  | Gender: M F  | Phone:  |
| **IMPORTANT** The Eligible Client has consented to this application Y N  |
| **APPLYING CLINICIAN** |
| Name:  | Organisation:  |
| Phone:  | Email:  |
| Date:  | Clinician Signature:  |
| **ITEM AND SUPPLIER DETAILS****Please attach evidence of costs** |
| Please provide a description and itemised costs for the requested funding:  |
|  |  |  |
|  |  |  |
|   |  |  |
|  |  |  |
| **Total funding requested in this application including any GST** | **$**  |
| Supplier Name:  | Contact Person:  |
| Phone:  | Email:  |
| **PAYMENT DETAILS****Payment will be by electronic transfer to either the retailer or the applying organisation** |
| Payment is to be made to: Supplier Applicant Organisation Reimburse Clinician  |
| Account Name:  | Bank and Account Number:  |
| **APPROVAL BY CYMHS CLINICAL COORDINATOR** |
|  Declined  |  | Approved |  | Amount | $ |
|  |  |  |  |  |
| CYMHS Clinical Coordinator |  | Signature |  | Date |
| Reason if application is declined:  | Applicant Notified: |