**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](mailto: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: | | | | | | | | | | | | |
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| **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: |