**HOW TO APPLY TO THE YAMHA & MANU KA RERE FLEXI FUNDS**

**PURPOSE**

To reduce barriers that prevent 13–24-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**

YAMHA and MANU KA RERE clinicians are eligible to apply to these funds 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, fully funded services)
* Must be submitted and approved before any funds are spent
* May relate to the provision of either group work or expenses for individual clients
* Funding for individual rangatahi recommended cap of $500 +gst

**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 Manu Ka Rere Team Leader are final
* Payment is made directly to the retailer; where this is impractical, the applicant’s organization may arrange payment which will be reimbursed upon presentation of a receipt and tax invoice
* Clinicians may opt to pay themselves (after approval) and submit a completed Reimbursement Form along with all relevant gst receipts
* It is the responsibility of the applying clinician to implement the intervention for their client
* Under no circumstances will flexifund administration communicate directly with clients
* flexifund payments must be complete within 3 months of the approval date
* clinicians are requested to provide a brief narrative of how the funding benefits their client
* Please have your application signed by your team leader

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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: | | | Phone: | |
| **APPLYING CLINICIAN** | | | | | | | | | | | | | |
| Name: | | | | | | Organisation: | | | | | | | |
| Phone: | | | | | | Email: | | | | | | | |
| **ITEM AND SUPPLIER DETAILS** | | | | | | | | | | | | | |
| 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: | | | | | | | |
| **HOW DO YOU INTEND FOR THIS TO BE PAID?**  **Payment will NOT be made directly to clients or their families** | | | | | | | | | | | | | |
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| **APPROVAL** | | | | | | | | | | | | | |
| Declined |  | | Approved | | | |  | Amount | | $ | | | |
|  | | | |  |  | | | | | |  | |  |
| Team Leader | | | |  | Signature | | | | | |  | | Date |
| Reason if application is declined: | | | | | | | | | | Applicant Notified: | | | |