Barrier Relief Supportive Service Referral Form
Behavioral Health Conditional Dismissal Program

Barrier Relief Supportive Services are defined as resources that Behavioral Health Conditional Dismissal Program (BHCDP) participants can draw upon to support treatment engagement and retention. Examples include tangible items such as safe and recovery-conducive housing, clothing, childcare, transportation and other supportive services that serve as barriers to recovery.

The Case Manager assigned to the BHCDP participant is responsible for completing this form. Requests must adhere to the parameters outlined within the BHCDP Barrier Relief Supportive Service Guide. Including the following:

- Requests must align with needs identified by the Case Manager as part of their treatment/recovery plan.
- Requests are subject to financial caps per service category and participant.
- Requests cannot include costs for treatment services. For treatment service reimbursement questions or requests please reach out to: Erin Henle at **EHenle@fletchergroup.org**
- Requests are only to be leveraged as the payor of last resort and the case manager must list any and all alternative relief sources previously applied for and subsequently denied/used. All previous requests for access to these funds will be considered prior to approval.
- Requests for payment/reimbursement is not guaranteed and more information may be requested prior to approval.

Upon completion, please email this referral form securely to: Kiki@ekcep.org

BHCDP PARTICIPANT INFORMATION

Date Request Submitted:

Participant Name:

Address:	Phone #:
County:	Email:

Type of Supportive Service Requested:

☐ **Housing Assistance**	**Amount: $**_____	**Vendor:** _____
☐ **Transportation**	**Amount: $**_____	**Vendor:** _____
☐ **Basic Needs**	**Amount: $**_____	**Vendor:** _____
☐ **Emergency Housing**	**Amount: $**_____	**Vendor:** _____

Please describe below the specific need(s), vendor(s), amount requested, and timeline of the request. Include how this request will help the individual achieve goals outlined within their treatment/recovery plan:

List alternative resources sought, provided or denied to fulfill this request:

BHCDP BEHAVIORAL HEALTH PROVIDER INFORMATION

Provider Name and Parent Entity if Applicable:

Case Manager/Staff Name:

Phone #:	Email:

Address:

BHCDP AOC Case Navigator Name:

PARTICIPANT RELEASE OF INFORMATION:

I recognize the above-listed BHCDP Approved Behavioral Health Provider, Case Manager, Case Navigator, and other BHCDP-related agents may communicate regarding my needs and any relevant personal identifiable information (PII) necessary to meet those needs. My signature below provides my permission to share this request and any necessary information to fulfill this request with EKCEP.

Participant Printed Name:_____

Participant Signature:_____

Date Signed:_____

{For Internal use only}

Date Received:	Approval: Yes ☐ No ☐	Notes:
Name of Approver:		Funds Released: Yes ☐ No ☐

EASTERN KENTUCKY
EKCEP
CONCENTRATED EMPLOYMENT PROGRAM, INC.

Signature of Approver:
Date Funds Released: