# Gap Funding Request Form

Please select the type of gap funding that you are accessing/requesting for the participant, complete the following information and retain with receipt, or if the request is not on the approved gap funding category list, send to the Administrative Assistant for approval.

**Please note that if a purchase is made that is not on the gap funding category list or exceeds $100 without prior, approval by BHD staff, the purchase will not be reimbursed.**

- ❑ Participant is requesting gap funding that is $100 or less and can be found on the gap funding categories list.
- ❑ The participant is requesting gap funding for an item that exceeds $100 for the 12-month period, or the item is not on the gap funding category list.

**Reason for Gap Request: Please include description of request, why it is needed, employment status and/or budget information, and participant's plan moving forward to cover similar expenses**

Name of participant: _____ ID/SID: _____

Name of provider: _____ Program Start Date:

Program: ❑ Free Through Recovery ❑ Community Connect

**Total Amount Requested:** _____

**Is the person requesting gap funding actively engaging with Care Coordinator and/or Peer Support?**

Choose One

**List in detail the community resources, agencies, or organizations that you have already tried to access resources and funds from. Include: Name of agency or organization, dollar amount they contributed (if applicable), or reason for denial.**

*Example: Last month we contacted Rent Bridge. Participant was denied due to landlord not participating in Rent Bridge.*

**Select the following categories in which the requested funds will help support the participant.**

| | | | |
|---|---|---|---|
| ❑ Housing | ❑ Transportation | ❑ Employment | ❑ Clinical Services |
| ❑ Basic Needs | ❑ Education | ❑ Communication | ❑ Family (NA if FTR) |

Date **Care Plan** last updated:

Date **Case Notes/Chronos** last updated:

**Gap Request must match a goal and/or action step**

**Include the following items when submitting request:**

- ❑ Copy of Lease (if applicable)
- ❑ Budget
- ❑ Proof of cost (quotes, web link, picture of item, copy of bill, etc.)
- ❑ Documentation of denial from other community resources (email, denial letter, etc.)
- ❑ Current Care Plan (Community Connect only)
- ❑ Current Case Notes (Community Connect only)

Participant signature: _____ Date: ____ / ____ / ____

Provider Care Coordinator signature: _____ Date: ____ / ____ / ____

Provider Fiscal Admin signature: _____ Date: ____ / ____ / ____

**If the Gap Request form is not filled out completely (i.e. sections not filled in or insufficient information) it will be returned and additional information will be requested.**

**Bottom section for use by Department of Human Services' Behavioral Health Division Administrative staff only**

---

**Request:** ❑ Approved ❑ Denied

**Comments:**

Administrator signature: _____ Date: ____ / ____ / ____

NORTH Dakota Be Legendary.™ | Corrections and Rehabilitation

CommunityConnect My Recovery. My Story.

FREE THROUGH Recovery

NORTH Dakota Be Legendary.™ | Behavioral Health HUMAN SERVICES