AdvancedHealth
Bridging the Future of Healthcare

FLEXIBLE FUND REQUEST FORM

Flexible Services are defined as services offered to an individual member to supplement covered benefits. Improving quality of health care is an important criterion for a service to be considered a flexible service and will have to meet the following criteria:

- Improve health outcomes compared to a baseline and reduce health disparities
- Improve patient safety, reduce medical errors, and lower infection and mortality rates
- Implement, promote, and increase wellness and health activities
- Be grounded in evidence-based medicine, widely accepted best clinical practice OR criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations.

(References: 410-141-3845; 410-141-3150)

Member Name: **Member ID#:**

Date: **Individual Requesting**:.

Is the individual an Advanced Health Member? ☐ Yes ☐ No

Has a care plan been created which supports the need for this request? ☐ Yes ☐ No

- Note: A Care Plan must be submitted with this request

Requested Amount:

Which of the following criteria does the flexible service meet? (Check all that apply)

☐ Improve health outcomes compared to a baseline

☐ Reduce health disparities

☐ Improve patient safety, reduce medical errors, lower infection, and mortality rates

☐ Addresses Social Determinants of Health and Equity (SDOH-E)

What is the reason for requesting flexible funds? (Check one)

☐ Care coordination, navigation or case management

☐ Food services and supports

☐ Housing services and supports

- ☐ Items for living environment to support a particular health condition
- ☐ Transportation services and supports
- ☐ Trauma informed services and supports across sectors
- ☐ Other non-covered clinical services and improvements
- ☐ Other non-covered social and community health services and supports

Please describe how the request relates to treatment plan or care plan objectives?

What other resources have been considered and why were they not sufficient/ available?

What is the expected outcome of this intervention?

- ☐ Prevent ED Visit
- ☐ Prevent Hospitalization
- ☐ Ensure Access to Needed Care
- ☐ Improve Health Condition
- ☐ Other: Click or tap here to enter text.

Recurrence/ length of Request:

- ☐ One-time ☐ Recurring
- ☐ Less than 6 months ☐ 6 months- 1 year ☐ More than 1 year

FLEXIBLE SERVICE REQUEST AUTHORIZATION

☐ **Approved** ☐ **Denied**

Account #:

Year-to-date Flexible Services ($) Received by Member:

Amount Approved:

Amount Payable to:

Request Authorized by: **Date:**

(Note: Upon denial, a written notification of a refusal of individual flexible services shall be provided to the member and any representative of the member or provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome.)