MISSOURI FIRE FIGHTERS
CRITICAL ILLNESS POOL

Residential/Inpatient Treatment Services

Grant Application Process

Individual

- Discusses circumstances of Residential/Inpatient Treatment with appropriate Regional Clinician
- Follows protocol for filing insurance and workers compensation
- Submits to the Regional Clinician:
    - Completed Residential/Inpatient Treatment Grant Application
    - Verification of completion of treatment
    - Residential/Inpatient Treatment Services Expense Voucher with all appropriate invoices, receipts, and payee information including a W-9.

Regional Clinician

- Evaluates application to determine eligibility
    - Approves Application
        - Notifies Individual
        - Notifies Program Manager of total dollars requested and supporting documentation for payment(s)
    - Denies Application
        - Notifies Individual of decision, justification or request for additional information
        - Individual resubmits application if appropriate

Program Manager

- Emails notice of Regional Clinician-approved Residential/Inpatient Treatment Grant Application to the Board for approval
- Following Board approval, submits request to Accounting for facility payment and/or Individual reimbursement for travel with supporting documentation.
- Updates Behavioral Health Program budget

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Behavioral Health Program
Residential/Inpatient Treatment Services Grant Application

Section I – Employer/Organization Information

Employer/Organization Legal Name	
Employer/Organization Address	HR Contact Name (To anonymously gather any information on program benefits not provided as requested below):
HR Contact Email	HR Contact Phone Number
Name of Employee Assistance Program (EAP) or Employer-Provided Behavioral Health Program if one is available to you	
Provide Employer/Organization provided EAP or Behavioral Health Benefit Plan (provide a website link, PDF copy of the entire plan, or plan summary)	
Contact Information of Employer/Organization Provided Behavioral Health Program (i.e, the EAP Insurer or Behavioral Health Benefit Plan Administrator)	

Section II – Individual Participant Information

Name	
Date of Birth	Participant Social Security Number - Last 4 digits
Mailing Address	Participant First Responder Employment Type Full-Time ☐ Part-Time ☐ Volunteer ☐
Phone Number	Participant Email
Job Title	Date Of Hire/Start Date
Significant Event contributing to need for Residential Treatment Services	Date of Incident (When care initially started)

Have all employer/organization provided coverage benefits including insurance, workers compensation, and EAP been applied for and received?
If no, please explain below, or attach a separate letter of explanation. ☐ Yes ☐ No

Section III – Behavioral Health Clinician & Facility Information

Clinician Name:

Facility Name:

Type(s) of Care your Clinician Provided during Inpatient Service:

Date of completion of Inpatient Service	Participant Balance (attach invoice)

A facility invoice showing charges for treatment and/or medications and balance due after insurance and workers compensation payments must be attached to this Grant application and Expense Voucher. Receipts and W-9 must be attached if requesting reimbursement of costs associated with reimbursement of travel expenses directly related to Residential/Inpatient Treatment Services.

Section IV – Other Funds Received, Fraud Warning, Release of Information (to be signed by Individual Participant)

Funds provided through this grant are intended to supplement Participant costs related to completing Inpatient Services, up to $10,000 per program period. In order for this application to be complete and valid, you must provide information regarding any and all other funds, benefits, or allowances you have received, or expect to receive, to help offset costs to include those received from your employer, organization, local union, social security or workers' compensation.

Any person who knowingly and with intent defrauds the Pool or other person files a reimbursement grant application with the Behavioral Health Program or a claim containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I authorize the release of information contained within and attached to this application for the sole purpose of the evaluation of grant eligibility.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Participant	Name of Participant (please print)	Date Signed

Send your completed grant application, supporting documentation and W-9 to the appropriate Regional Clinician.

Questions may be directed to the appropriate Regional Clinician, Regional Coordinator or Sherry Sweet at Sherry.MFFCIP@gmail.com or 573-619-7216.