Request for Special Needs Bridge Funding (BF)

Types of special needs bridge funding (BF)
Request for Special Needs Bridge Funding (BF)
Request for Specialized Treatment Funding

Purpose of request: *To collect information necessary to determine the need for bridge funding (BF) in an effort to assist individuals who have a Serious and Persistent Mental Illness (SPMI) diagnosis and who have been in the hospital more than 45 days and may otherwise remain in the hospital due to lack of resources. Requests for BF should only be submitted when* ***due diligence for DBHDD as payer of last resort has been confirmed.***

To ensure everything is in place at the time of discharge, it is essential to start planning for the individual's needs utilizing information gathered from the Individual Recovery Plan (IRP) and the initial Transition Action plan (TAP) meetings to determine resources. Applications for bridge funding should to be submitted when a lack of individual resources are a barrier for discharge from the hospital. Adequate time should be allotted for the request approval while focusing on the individuals discharge date.

In most instances, our state hospitals can get the lowest cost on medication. Therefore, medication requests should go through the state hospital. In most cases, BF for medication is time limited to 30 days.

If a psychiatric medication is in the Medicaid formulary as a preferred medication and the provider is a safety net provider- Community Service Board (CSB) it is expected the CSB will cover the psych meds. Access to the Preferred Drug List (PDL) Medicaid formulary is listed below. Note: use the generic equivalent when checking the web portal.

To access this document, go to
http://DCH.Georgia.gov web site and search for:
Georgia Medicaid/PeachCare Preferred Drug List

Process for review: *The Hospital Social Worker will complete the request and submit to the Regional*

Field Office Transition Specialist (RFO TS)*, to include all necessary documentation to support the request.* ***The Social Worker will clearly document efforts to ensure all resources have been explored and exhausted in the narrative. The narrative should confirm Prior Authorization (PA), the application for Pharmacy Assistance Program (PAP) and the status of the application.***

RFO TS *vets request and reviews for accuracy. TS and RSA sign and forward to AMH for approval and processing.*

AMH *will notify region of receipt of the request. Approval or denial, will be given within 5 days of submitting a completed, comprehensive request. AMH will submit a "Claim" for processing.*

Applications that are incomplete, do not have supporting documentation, and/or submitted post discharge may not be approved.

Forward form to: Community.Residential@dbhdd.ga.gov

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Clear Form

Hospital & Region Information			
Date of Submission:			
Name of Hospital:		Region of Origin:	
Social Worker (SW):		Region of D/C:	
SW Email Address:		SW Telephone #:	
RFO Transition Specialist:		RFO Service Administrator:	

Personal Information			
Name:		Admission Date:	
DOB:		# of Prior Admissions:	
CID#:		DSM Code: (ex. F20.9)	
Identified Gender:		Anticipated Discharge Date:	
Community Provider:		Medication Provider:	

Personal Narrative

Please provide a brief narrative relevant to the individual's specific situation. Include SPMI diagnosis. Document due diligence for DBHDD as payer of last resort, i.e. family supports, personal income including any funds available in the hospital account, bank accounts, religious organizations, eligibility for pharmacy assistance (PAP) including status of the application, etc. Include information regarding the status/outcome of assisting the individual to apply/reapply for disability benefits/Medicaid/Medicare Part D. etc....

Plan for Continuation of Services after bridge funding ends:

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Personal Resources						
Resources	**Amount / Eligible Amount**	**Denied**	**Received**	**Waiting List**	**Pending**	Clear Row
Hospital Trust Account		☐	☐	☐	☐	☐
SSI		☐	☐	☐	☐	☐
SSDI		☐	☐	☐	☐	☐
Medicaid		☐	☐	☐	☐	☐
Medicaid Waiver (HCBS or DD)		☐	☐	☐	☐	☐
Medicare		☐	☐	☐	☐	☐
Personal Bank Accounts		☐	☐	☐	☐	☐
State GIA Funds		☐	☐	☐	☐	☐
Natural Supports		☐	☐	☐	☐	☐
Private Insurance		☐	☐	☐	☐	☐
Food Stamps		☐	☐	☐	☐	☐
Railroad Pension		☐	☐	☐	☐	☐
VA Assistance/Pension		☐	☐	☐	☐	☐
Homeless Assistance Program		☐	☐	☐	☐	☐
Religious Groups		☐	☐	☐	☐	☐
Civic Organization		☐	☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐	☐
Total Financial Resources	$ 0.00					

Please describe below the reason why the individual is not able to access funding through any of the personal financial options listed in the "Personal Resources" section to cover transition cost.

One-Time Transition Costs/Services	
First Month Rent	
Second Month's Rent *(if discharged after the 10th of the month)*	
Medication	
Food/Grocery	
Essential furnishings	
Initial household goods and supplies	
Household Furnishings	
Moving expenses	
Transportation	
Security Deposits (Rent/Lease)	
Utility deposit	
Fees (specify type)	
Other (specify)	

Total Request: $ 0.00

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Description of Services/Items requested: ***service, item, name, location/address, name of residential provider ect.)*:**

Attachments			
BF request form	☐	**Invoice (other items requested)**	☐
Invoice for Rent (month 1)	☐	**Social Security Award Letter**	☐
W-9 and one of the following: IRS Form **147C** or IRS Form **CP575A** or Landlord Social Security card	☐	**Safety and/or Crisis Plan**	☐
Other	☐		

Signature Acknowledgement

By signing this form, you are verifying the request for funding to support the transition of the above named individual is needed and that ***due diligence has been met.***

Hospital Social Work Signature	*Print Name*	*Date*
RFO Transition Specialist Signature	*Print Name*	*Date*
RFO Regional Support Administrator Signature	*Print Name*	*Date*

For Office of Transition Services Use Only

Approved:	☐ Yes ☐ No		
Total Approved:		Date of Approval:	
Reason for Denial:		Date of Denial:	
Invoice Received:	☐ Yes ☐ No	Date Received:	
Request Forwarded for Processing:	☐ Yes ☐ No	Date Forwarded:	
Signature for Funds Dispersal:			