OPC Developmental Disabilities
Flex Fund Request

Applicant's name____________________________ DOB:____________ Date of Request: _________

Address_________________________________ Is Parent/Guardian/Client making request or aware

_________________________________ request is being made? Yes ☐ No ☐

Place of Residence: Chatham Co. ☐ Person Co. ☐ Orange Co. ☐

Name of Parent/Guardian(s)____

Home phone: ____________________ Work phone: ____________________

E-Mail Address: ____________________

Service Coordinator/ Case Manager/Contact Person (phone, fax and e-mail):

Resources used by the family:

CAP-MR/DD	☐	☐
CAP-C	☐	☐
CAP-DA	☐	☐
Medicaid	☐	☐
Health Choice	☐	☐

Has person been screened by OPC?
Yes ☐ No ☐

Please list all disabilites:

____

Description of request:

____

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List other resources that have been investigated:

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Please describe how this request will impact the individual with a disability:

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If your request is subsidized by DD Flex Fund, how will you be able to meet this financial need after your funding has ended?:

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Name, mailing address and Tax ID# or SS# of Vendor to whom check will be issued:

____
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____

Exact amount being requested:____

My signature indicates that I give permission for information regarding this request to be shared with (check all that apply):

- ☐ OPC Area Program
- ☐ Person completing this request (i.e. case manager, service coordinator, etc.)
- ☐ Vendor
- ☐ Other (please list) ________________________________

Information retained in this request will be kept confidential. Authorization expires automatically one year from date submitted.

Signature of Applicant or Parent/Legal Guardian:____

Signature of person completing form: ____

Total Amount Approved:____________

Submit request to:

Cheryl Uphoff-Moran
DD Services Authorizer
OPC Area Program
100 Europa Drive Suite 490
Chapel Hill, NC 27517
(919) 913-4136
Fax: (919) 913-4001