Care Grant Request Form

Date:	Phone # of person submitting form:
Name of Lead Agency staff or Transitioning Adult member submitting form:	
Name of Lead Agency (if applicable):	
Address of Lead Agency or adult member:	

Post Adoption ONLY *(For members who have been adopted and qualify for the Adoption Assistance within Medicaid.)*	
Parent Name:	Parent Phone #:
Address of Parent:	

**Note: Completion of a W-9 form is required if adult member or adoptive parent is the requester. Payment is made directly to the adult member or adoptive parent.*

Member Name:	
Member Medicaid #:	Member DOB:
List items/services Care Grant is being requested for:	
Please describe how these items/services benefit the member's health, safety and/or wellbeing:	
List efforts made to seek alternate funding for items/services requested that are <u>not covered</u> by Medicaid:	
Description of supporting documentation of cost submitted with this form (Care Grant requests submitted to Sunflower without supporting documentation cannot be processed)**:**	
Total Care Grant Amount Requested: $ *($150 limit per calendar year.)*	**Has this member received this funding previously?** ❒ Yes ❒ No

Email this form and supporting documentation to AUGfostercareks@sunflowerhealthplan.com or fax to 833-404-2994.

Sunflower Health Plan Internal Use Only:

❒ Approved ❒ Partially Approved ❒ Denied	Initials/Date
If denied or partially approved, reason:	
Date processed:	