WORCESTER COUNTY
LOCAL BEHAVIORAL
HEALTH AUTHORITY
Working together for healthier communities!

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY

REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

Purpose: To assist Worcester County residents in the Public Behavioral Health System with payment of needed services or support to maintain their stability in the community. These funds may be used for rent, utilities and other personal items or services. The approval for funding will be limited to one time per fiscal year.

Eligibility:

- Individual is actively involved in the Public Behavioral Health System (PBHS);
- Funds are being used to alleviate a problem and shall be linked to the individuals clinical treatment, rehabilitation, or recovery plan goals;
- Individual has no other personal financial resources to cover incurred expenses;
- All other resources have been exhausted; and
- At least three charitable or religious organizations have been contacted and cannot assist.

Instructions on completing application:

1. Complete Application, answer all questions in detail in Section I (make sure question 11 does not have any blanks. All areas should have an amount or N/A listed by each item).

2. Complete Release/Obtain Information Form (**application cannot be processed without a release for all individuals and/or agencies associated with the Consumer Support application that may be of assistance to the WCLBHA when processing the request**).

3. Attach supporting documentation to Consumer Support Application (Letters from organizations, case managers or therapists denying/approving ability to assist client with financial assistance, bills and leases that show amount owed that verify funds being requested, etc.).

4. Attach Proof of income from all household members and from all sources.

5. Provide name, address, telephone number and federal ID number of vendor to be paid on individual's behalf.

6. Deliver, fax or send via secured email the completed form and supporting documentation to Worcester County Local Behavioral Health Authority (WCLBHA). Fax number 410-632-0065. WCLBHA Director or Designee will review and process the application and will contact individual's worker/therapist (if they submitted the request) and applicant of approval or denial.

7. Consumer Support Funds use is governed by the requirements and conditions set forth by the Behavioral Health Administration (BHA). Requests exceeding $1,000.00 will not be considered. WCLBHA may require use of funds from other agencies in addition to WCLBHA funding.

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SECTION I. To be completed by referring party

Date of Request: _____

[ ] adult
Client Name: _____ [ ] child/adol

DOB: _____ Social Security Number (optional): _____

Address: _____

Phone Number: _____

Provider/Program Name: _____

Contact Person and Phone Number: _____

Eligibility Criteria

1. The client must be actively in the Public Behavioral Health System. Their ICD-10 Diagnosis_____
   Date of Last Appointment _____ Date of Next Appointment _____
2. Has the client received support from the LBHA in the past? Yes _____ No _____
   If yes, please provide date: _____
3. Number of children in the home? _____
4. Number of roommates: _____. Is this request made on behalf of all roommates? _____
5. Indicate any Housing Programs client has received or applied for (Shelter Plus, Section 8, Rental Assistance, RRP, etc.) _____
6. Please list at least **three** (3) other resources that have been contacted for support and the reason for denial:
   _____
   _____
   _____
7. If this is an educational expense, List the name of the person who verified this is a part of the service plan and DORS or other funding is not available: _____
8. Describe the goods or services to be purchased on behalf of the client and the reason for the need.
   _____
9. Explain how the expenditure will assist the client in meeting his/her individual behavioral health treatment or rehabilitation goals (provide copy of goals/plan or letter from the provider). _____
   _____
10. Provide a specific plan indicating how the client intends on making payments in the future and prevent future need for emergency assistance. _____
    _____

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11. **Please provide *all* monthly income and expenses**:

Monthly Household Income:

Wages: $_____
SSI/SSDI: $_____
Child Support: $_____
Food Stamps: $ _____
Other: $_____
Total: $_____

Monthly Household Expenses:

Rent: $_____
Electric/Gas: $_____
Water: $_____
Phone: $_____
Transportation: $_____
Cable/Internet: $_____
Food: $_____
Other: $ _____
Total: $_____

12. **Attach an itemized quote or invoice from the vendor that verifies/explains the cost for the goods/services**.

$_____ Total cost of goods/Services

$_____ Amount to be paid by client (If zero, requester certifies client cannot afford payment)

$_____ Amount to be paid by sources other than LBHA

$_____ Amount of vendor discount, if any

$_____ **Amount Requested from Local Behavioral Health Authority**

13. **Vendor Information:**

Name:_____

Address: _____

Telephone: _____ Date vendor must receive payment: _____

If approved, make check payable to _____ Fed ID#_____

SECTION II: To be completed by the WCLBHA Director/Designee

APPROVED: _____ ***Amount***: _____ ***Payable to*** _____

DENIED: _____ ***COMMENTS***: _____

_____

Signature of WCLBHA Director/Designee: _____ ***Date***: _____

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CONSENT TO *release/obtain* CONFIDENTIAL INFORMATION

In order to ensure continuity of care, I, _____

authorize Worcester County Local Behavioral Health Authority to obtain information from Worcester County Health Department - Behavioral Health and release information to Worcester County Local Behavioral Health Authority for the purpose of payment arrangements for: _____
_____.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

If my records include Drug and Alcohol Treatment, I understand my records are protected under the Federal Confidentiality Regulations* and cannot be disclosed without my written consent, unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (such as Parole and Probation, etc.) and that in any event this consent expires automatically as described below. I have given this consent of my own free will. *Federal law prohibits re-disclosure except as provided for 42 CFR Part 2. And that in any event this consent expires:

__**X**__ After one year from the date of execution.
_____ When the patient ceases to receive services from either agency.
_____ Other (Please specify)_____

Executed this _____ day of _____, 20_____

DOB: _____ _____

Signature of Consumer, Parent, or Guardian

_____

Signature of Witness

PLEASE DIRECT ALL CORRESPONDENCE TO:

Worcester County Health Department
Local Behavioral Health Authority
PO BOX 249
SNOW HILL, MD 21863

ATTENTION: **Worcester County Local Behavioral Authority**

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CONSENT TO *release/obtain* CONFIDENTIAL INFORMATION

In order to ensure continuity of care, I, _____,

authorize Worcester County Local Behavioral Health Authority to obtain information from (landlord, utility/water company, etc.), _____ for the purpose of payment arrangements for: _____
_____.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

If my records include Drug and Alcohol Treatment, I understand my records are protected under the Federal Confidentiality Regulations* and cannot be disclosed without my written consent, unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (such as Parole and Probation, etc.) and that in any event this consent expires automatically as described below. I have given this consent of my own free will. *Federal law prohibits re-disclosure except as provided for 42 CFR Part 2. And that in any event this consent expires:

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