WORCESTER COUNTY
LOCAL BEHAVIORAL
HEALTH AUTHORITY

Working together for healthier communities!

REQUEST FOR MENTAL HEALTH CLIENT SUPPORT SERVICES
RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

Purpose: Enable Worcester County adult residents access or retain community-based mental health services. Funding and need shall be linked to the client's treatment, rehabilitation, or recovery plan goals. Funding will be utilized as a last resort for the purchase of emergency goods and the provision of time-limited services, one time per fiscal year.

Eligibility:

- Mental Health Client Support Services is governed by the requirements and conditions set forth by the Behavioral Health Administration (BHA). Requests exceeding $1,000.00 will not be considered unless it is a life and/or safety issue; and
- Individual is actively engaged in Fee-For-Service Public Behavioral Health System (PBHS) funded outpatient mental health treatment; and
- Funds are being used to alleviate a problem and shall be linked to the individual's clinical treatment, rehabilitation, or recovery plan goals; and
- Individual has exhausted all other community, private, individual or family resources to cover incurred expenses; and
- The Individual has applied to at least three other charitable or religious organizations and they were unable to assist.

Instructions on completing application:

- Answer **all** questions and do not leave blanks; place zeros or N/A if it does not apply.
- Complete **all** Release/Obtain Information Forms for individuals and agencies involved with this request.
- Attach **all** documentation to the application that is needed to make payment to the vendor (W9 tax forms, lease, receipts of payment, utility bills, etc.).
- Attach **Proof of income** from **all household members** and **sources** (Wages, TCA, SSI/SSDI, Child Support, SNAP, etc.).
- Attach treatment, rehabilitation, or recovery plan with goals.

Submit completed application and supporting documentation to Worcester County Local Behavioral Health Authority (WCLBHA) in person, via Fax 410-632-0065 or encrypted email at debra.harmon1@maryland.gov. WCLBHA Director or Designee will review and process the application and will notify the person making the request of the approval or denial of the application.

Consumer Support Application Checklist

Please provide the following information along with the Consumer Support Application to the Worcester County LBHA, Attention Debra Harmon:

- ☐ **Completed Application**
- ☐ **Authorization to release/receive information** for Worcester County LBHA and Worcester County Health Department - signed and dated (needed to discuss with the worker).
- ☐ **Multiple Authorizations to release/receive information** for the Landlord/Utility Company or other businesses and the Worcester County LBHA - signed and dated (this is needed so we can discuss clients needs and what we need from the company/landlord or others to process the application).
- ☐ **Treatment Plan with Goals from Provider** - This is a requirement set by Behavioral Health Administration to support the need of the request and proves the client is actively in treatment.
- ☐ **Documentation from three other resources/businesses/churches** that client or worker requested funds to help the client (letters, emails, copy of receipts of payment).
- ☐ **Income** - Attach income for client and all household sources, including other household member's income (Wages, SSI/SSDI/SS, Child Support, Alimony, SNAP, TCA, etc.).
- ☐ **Lease/Mortgage** - The lease must be current/valid (not expired) if requesting rental assistance.
- ☐ **W9 Form** - The form must include business name, address, type of business, Federal Tax ID number or Social Security Number. Must be signed and dated by the authorized person at the place of business.
- ☐ **Bill or Statement** - Bill/statement should reflect what is currently owed on the client's account - signed and dated by the landlord/business.
- ☐ **Receipts/Canceled Checks** - Copies of receipts from client if they paid a portion of the expense and from the other churches/businesses that contributed to the financial request.

Applications for General Reasons, Pharmacy, Lab and Transportation can be obtained from Worcester County Health Department's website: https://worcesterhealth.org/planning-sidebar/local-behavioral-health-authority-lbha under Forms near the bottom of page.

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY

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

SECTION I. Consumer or the referring party shall complete <u>all</u> sections of the form or request will be denied.

Date of Request: _____

Client Name: _____ (**Adults Only**)
DOB: _____ Social Security Number (optional): _____
Address: _____
Phone Number of Consumer: _____
Provider/Staff's Name of Who is Making the Request: _____
Provider/Staff's Phone Number: _____

Eligibility Criteria

1. The client must be **<u>actively</u> <u>receiving</u>** services in the Public Behavioral Health System.
   Provide Their ICD-10 Diagnosis _____ Date of Last Appointment _____
   Date of Next Appointment _____ Receiving Medicaid? Yes _____ or No _____
   Receiving Medicare? Yes _____ or No_____

2. Has the client received support from the LBHA within the past 12 months? Yes _____ No _____
   If yes, please provide date: _____

3. Please **<u>list a minimum of three (3) other agencies/programs and their contact information</u>** that the client or their worker contacted for assistance and the reason that the client was denied funds:
   - _____
   - _____
   - _____

4. 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: _____

5. Describe the goods or services being requested and the reason for the need (attach documentation such as itemized bills, lease, etc.).
   _____

6. Describe how the funds will help the client meet his/her mental health treatment, rehabilitation or recovery goals (attach a copy of client's goals/plan from their treatment provider).
   _____
   _____

7. Provide a detailed plan how the client will meet this need without the use of Mental Health Client Support Services in the future. _____
   _____

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY
REQUEST FOR FINANCIAL ASSISTANCE FOR
RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

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

Monthly Household Income (attach proof of income):

Wages: $_____
Retirement: $_____
SSI/SSDI: $_____
Child Support: $ _____
SNAP/FS: $_____
Other: $_____
Total: $_____

Monthly Household Expenses:

Rent/Mortgage$_____
Electric/Gas: $_____
Water/Sewer $_____
Phone: $_____
Transportation: $_____
Cable/Internet: $_____
Food (cash used, not including SNAP: $_____
Other: $ _____
Total: $_____

9. **Attach an itemized bill or invoice from the Agency to be paid that verifies/explains the cost for the goods/services**.

$_____ Amount owed/due for the goods/services prior to payments received/applied.
$_____ Amount paid by client (attach receipt); subtract from the amount owed.
$_____ Amount paid/will be paid by sources other than LBHA; subtract from the amount owed.
$_____ **Total Amount Requested from Local Behavioral Health Authority.**

10. **Agency/Vendor information who requested/will receive the payment (Attach their W9 Tax Form):**

Name: _____
Address: _____
Telephone: _____
Make check payable to _____ Fed ID# or Social Security Number _____
_____

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

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

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

_____

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

Maryland
DEPARTMENT OF HEALTH

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Use a separate form for each individual, program, organization or facility with which information may be shared.
Please type or print as clearly and completely as possible.

Reset Form

1 **Patient name** _____ **Date of Birth** _____

2 **I hereby authorize and request the following party to ☐ release ☐ receive information**

_____
Name of individual, program, organization or facility

_____
address

3 **☐ to ☐ from the following party** _____
Name of individual, program, organization or facility

_____
address

4 **The following information (INITIAL all items covered by this authorization):**

_____ **Acknowledgment of receipt of services**

_____ **Complete program record (includes all items below):**

_____ Intake assessment _____ Treatment plan _____ Progress notes _____ Diagnosis

_____ History/Physical _____ Lab Results _____ Service/discharge summary

_____ Medications _____ Immunizations _____ Identifying Information

_____ Billing Records _____ Photographs, Video, Digital or other images

_____ Mental health _____ Records from other providers contained in the program record

_____ **Other (specify)** _____

_____

_____ **Alcohol or other drug treatment records (requires specific authorization). Specify below.**

_____ Complete record _____ Assessment results/history _____ Treatment/service plan progress/compliance

_____ Other (specify) _____

5 **The disclosure is for the following purpose(s) (Check all that apply):**

☐ Patient request ☐ Treatment/continued care ☐ Review current care

☐ Payment ☐ Insurance application ☐ Legal

☐ Other (please explain) _____

_____

6 **This authorization expires one year from the date the form is signed unless I indicate an earlier date or event *(must occur sooner than 1 year from the date of my signature)* here:**

Until Date: _____ **OR** Until specific event: _____

7 **I understand the following:**

a. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.

b. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.

c. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.

d. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.

e. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

8 **Patient Signature** _____ **Date** _____

Parent or Personal Representative Signature *(if applicable)* _____ **Date** _____

If signed by Parent or Personal Representative, please indicate Relationship to Patient

☐ Parent of Minor Child ☐ Guardian ☐ Authorized Representative

☐ Other_____

NOTICE

Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.

If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.