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

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY
REQUEST FOR LABORATORY SERVICES

Purpose: To assist Worcester County residents in the Public Behavioral Health System with payment for laboratory services to monitor psychiatric medications. Funds are available to persons who do not have Medicaid or Medicare Insurance. The approval for funding will be limited to one time per fiscal year.

Eligibility:

- Individual is involved in the Public Behavioral Health System (PBHS);
- Lab work must be related to the individual's Behavioral illness;
- Individual has no personal financial resources to cover incurred expenses
- All other resources have been exhausted; **and**
- No charitable, or religious organizations, or individuals can assist.

Instructions on completing the application:

1. Complete all information in the application under Section I and attach all documentation used to verify and process request (client's Lab Bill, Income, other resources attempted, etc.).

2. Eligibility must be verified. Usually, the client's therapist, case manager, advocate, social worker, etc. will be assisting client with filling out this application and should verify the above eligibility requirements have been met.

3. Complete Release/Obtain Information form (**application cannot be processed without it**) for all individuals and/or agencies associated with this Lab Service Application, should the WCLBHA need to contact them for additional information.

4. The WCLBHA Director or designee will complete Section II and notify applicant and caseworker/therapist/etc. (if applicable) of the approval or denial.

5. Deliver the completed application and release/obtain information form to the WCLBHA or fax it to 410-632-0065.

6. The use of Client Support Funds is governed by the requirements and conditions set forth by the Behavioral Health Administration (BHA). BHA may require written approval for amounts exceeding certain limits. The WCLBHA may require a co-payment or use of funds from other agencies in addition to WCLBHA funding.

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY
REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR LABORATORY SERVICES

SECTION I. To be completed by the referring party

Date of Request: ________________

Patient Name: ____ ☐ child/adolescent ☐ Adult

DOB: _____________________ Social Security Number (Optional): ___________________________

Address: ____

Phone Number: ____________________Parent/Guardian (if applicable) _________________________

Provider/Program Name: ____

Contact Person: ____

Eligibility Criteria

1. Is the client in the Public Behavioral Health System? ☐ Yes ☐ No

   ICD-10 Diagnosis: ____

2. Has the client received support from the LBHA in the past Fiscal Year? ☐ Yes ☐ No

   If yes, please provide date when support was received: _____________________________________

3. List all sources of income and benefit amounts (Employer/TCA/MA/Medicare/SSI/SSDI):

   ____

   ____

4. Name of person who verified client's inability to pay and met other eligibility requirements?

   ____

5. Reason for lab testing: ____

6. Test/Profile and Cost: ____

SECTION II: WCLBHA Director/Designee

☐ Approved Amount Approved: ____________ 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
____

and release information to ____

for the purpose of lab order expenses.

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
Worcester County Local Behavioral Health Authority
P.O. Box 249
Snow Hill, MD 21863