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

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

Purpose: To assist Worcester County residents in the Public Behavioral Health System with payment for psychotropic medication or a medication that supports the administration of a psychotropic medication from a physician. Funds are available to persons who do not have Medicaid or MCHP 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);
- Individual has a Physician order for prescribed psychotropic medications or medications that support the administration of a psychotropic medication;
- Individual has exhausted Medicare Part-D Coverage and has applied for MCHP or Medical Assistance;
- Individual has no personal financial resources to cover incurred expenses;
- All other resources have been exhausted (Physician samples, Pharmaceutical Companies Indigent Medicine Program, Med Bank, etc.); and
- No charitable, or religious organizations 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 prescription order, 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 Medication Assistance 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. Collection of a co-payment will be made for this service.

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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. Please list three (3) resources that have been contacted for support and reason for denial:

   _____

   _____

   _____

6. Did the client/individual request Medication samples, if yes, were they available? ☐ Yes ☐ No

7. Did the client/individual complete and submit an application for Medical Assistance (Medicaid or MCHP)? ☐ Yes or ☐ No? If yes, **date the application was completed**: _____

   If no, please explain: _____

   _____

   Date of denial: _____ Date of approval: _____

8. Did the client/individual apply for assistance through the pharmaceutical company's patient assistance program? ☐ Yes or ☐ No Comments: _____

   _____

9. List the Pharmacy's name and telephone number that was called by client/referring party to determine the cost of medication (Generic medications will be provided when available):

   _____

Medication Name(s)	**Cost of Medication**
_____	$_____
_____	$_____
Total Cost of Medication(s):	**$_____**

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 prescribed medication 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