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

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

Purpose: To assist Worcester County residents in the Public Behavioral Health System with payment of transportation services. The approval of funding will be limited to one time per fiscal year.

Eligibility:

- Individual is involved in the Public Behavioral Health System (PBHS);
- Transportation is needed to access PBHS sponsored mental health services;
- Medical Assistance is unable to provide transportation for the individual;
- 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 for completing the application:

1. The referring party (client's therapist, case manager, advocate or social worker) making the request on the client's behalf (applicant), must verify the information under the eligibility section above.

2. Complete all information in Section I, and answer all questions under Eligibility Criteria. The WCLBHA Director or designee will complete Section II and notify applicant of approval or denial.

3. Please complete the Consent to Release/Obtain Confidential Information form. The application **cannot** be processed without the Consent to Release/Obtain Information form. Please ensure that a release is completed for any person, agency or organization that is involved with the assistance application, should the WCLBHA need to contact them for additional information.

4. Deliver or fax the completed application, releases and forms to the WCLBHA for authorization at 6040 Public Landing Road Snow Hill, MD 21863 or fax **410-632-0065**.

5. The use of Client Support funds is governed by the requirements and conditions set by the Behavioral Health Administration. 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.

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SECTION I. To be completed by the referring party

Date of Request: _____

Client Name: _____ ☐ Adult ☐ Child/Adolescent

DOB: _____ Social Security Number (Optional)_____

Address: _____

Phone Number: _____

Provider/Program Name: _____

Contact Person and Phone Number: _____

Eligibility Criteria

1. Is the client in the Public Behavioral Health System? Yes_____ No: _____
   ICD-10Diagnosis: _____
2. Has the client received support from the LBHA in the past? Yes_____ No_____
   If yes, please provide date: _____
1. Please provide **all** monthly income and benefit amounts (i.e., Wages, SSI/SSDI, TCA, MA, etc.):
   _____
   _____
2. Please provide the name of person who verified client does not have resources for transportation services?
   _____
3. Transportation Provider: _____

From: _____ To: _____ Date: _____
_____ _____
_____ _____

From: _____ To: _____ Date: _____
_____ _____
_____ _____

SECTION II: WCLBHA Director/Designee

Approved: _____ **Denied**: _____

Comments:

_____

_____

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

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In order to ensure continuity of care, I, _____

Worcester County Local Behavioral Health Authority to obtain information from _____

_____

and release information to_____

for the purpose of transportation needs.

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
PO BOX 249
SNOW HILL, MD 21863