Public Health
Prevent. Promote. Protect.
Somerset County
Health Department

Somerset County Health Department
8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 Fax 410.651.5680 TDD 1-800-735-2258

Health Officer: Danielle Weber, MS, RN

Maryland RecoveryNet (MDRN)
Substance Use Disorder (SUD)
Client Support Services

Phone 410-621-5739 Fax 410-621-5426

Complete this form and Individual's Authorization form(s)

1. Client Name: _____ DOB: _____ SS#: _____

Sex: M / F Race: _____ **Substance Use Diagnosis:** _____

Address: _____ Phone #: _____

_____ County: _____

# of Adults in Household (**list names**) _____

# of Children in Household (**list names)** _____

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2. Is the individual presently a State Care Coordination Client? Yes ___ No___

3. Is the individual presently a Client of the Public Behavioral Health System? Yes ____ No ____

Substance Abuse Health Provider: _____

How long has the Client been in substance abuse treatment and are they compliant with appointments and treatment plan? (*Brief description*)

_____

_____

Does the Client have Medical Assistance? MA#_____ Yes___ No____

Has the Client applied for Medical Assistance? Yes___ No____

Date of Application_____

Does the Client have Medicare? Yes___ No____

Is the Client uninsured (Gray Area) and registered as such in the PBHS? Yes___ No____

Gray Area identification # _____

4. What assistance is being requested? Please provide brief description of assistance needed:

_____

_____

_____

Is the individual (household) capable of paying for this item(s)? Yes___ No____

Is there any other resource that could have paid for this item(s)? Yes___ No____

Total dollar amount requested: $_____

MDRN Funding will only pay up to $1000 once in a fiscal year

5. If Client is requesting coverage of a recurring cost, provide *specific* details as to why the Client is unable to cover cost(s) themselves and how they plan to budget for this need in the future.

_____

_____

_____

Please note all income and monthly expenses; documenting need for financial assistance: Income MUST exceed expenses or application will be denied.

Total Monthly Household Income:		**Expenditures:**	
Wages	$	Rent	$
Assistances (SSI, SSDI, TDAP, TCA, food stamps)	$	Electric	$
Other: (child support, financial aid, rental income)	$	Gas/propane/heating	$
Total	**$**	Phone/cell	$
		Food Stamps	$
		Food cost (other than food stamps)	$
		Water Bill	$
		Transportation (car payment/insurance, bus, taxi)	$
		Cable/Internet	$
		Other	$
		Total	**$**

6. Check should be made payable to: (cannot be made payable to Client)

Name: _____

Address: _____

_____

Telephone #_____

Checks can only be made payable to business providing services to the

7. Please list all agencies that have been contacted and note reasons for approval/denial.

Minimum of 3 required.

Agency Name:	Contact Person:	Telephone #:	Reason Denied:
1.			
2.			
3.			

Agency Representative Signature: _____ **Date:** _____

Print Name: _____ **Phone#/Ext:** _____

Agency Name: _____ **Fax #:** _____

Please ensure checklist is complete before submitting application: (*mark box with a check*)

- □ **A separate Release of information for each agency/business will need to be completed so the LBHA can call to discuss the application.**
- □ **If you are not the substance abuse (SUD) provider, have you included a Release of information for the Clients Treatment provider?**
- □ **Have you included a copy of the utility bill, past due rent notice or eviction papers?**
- □ **Have you included evidence of all monthly household income (paystubs, SSI or other type of benefit letter)?**
- □ **Have you included a copy of the prescription or lab request if applicable?**
- □ **If requesting Pharmacy Assistance please provide a copy of the prescription(s) Note - LBHA can assist with behavioral health disorder medication which supports the administration of a medication related to a behavioral health disorder.**
- □ **All sections of this application are completed in its entirety and supporting documentation is attached.**
- □ **Have you included a copy of the individual's treatment or recovery plan?**

LBHA USE ONLY

Approved ☐ Amount _____ Denied ☐ Date: _____

Comments: _____

_____

_____

_____

Signature: _____ Signature: _____

Director / Health Department Designee LBHA Coordinator

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Authorization for the Release of Confidential Information

Client Name: _____ DOB: _____ Patient ID# _____

Street Address: _____City, State, Zip: _____

Phone Number: _____

I hereby authorize the Somerset County Health Department to: X Obtain X Release information to / from:

_____

The following information from my records (specify extent or nature of the information to be obtained or released):

_____

The purpose of this authorized disclosure:

_____

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 and 164. These regulations prohibit you from making further disclosure of it without the specific written consent to whom it pertains or as otherwise specified by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Conditions for Exchange of Authorized Information
Expiration: This authorization will expire one year from the date signed unless specified below by date or event less than one year: Date:

_____/_____/_____ Event or Condition:

_____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice, but not retroactive to release of information already made in good faith. USE SPACE BELOW ONLY IF CLIENT WITHDRAWS CONSENT.

Date Authorization Revoked by Client: _____/_____/_____ Signature of Client: _____

REDISCLOSURE: Any individual or agency receiving Somerset County Health Department client information is prohibited from making further disclosure of the medical record. This is prohibited as provided by the Annotated Code of Maryland 4-303(b)(5)(ii).

PHOTOSTAT/FACSIMILE: A photostat or facsimile of this authorization is considered as effective and valid as the original.

Date: _____
Signature of Client: _____
_____

Date: _____
Signature of Parent or Guardian: _____

Date: _____ _____
Witness to Signature: _____