**Instructions for completing the Somerset Behavioral Health Authority / Somerset Core Service Agency Consumer Support and Individual’s Authorization forms**

|  |  |
| --- | --- |
| **Consumer Support form: The sections/questions are numbered to allow for easier explanation of what is required. The request will be returned if all sections applicable to the request are not completed.** | |
|  |  |
| 1. | Name of consumer and requested information should be written here, even if client is a child. If consumer is a child enter parent of guardian information where specified. |
|  |  |
| 2. | Individual must be a consumer of the Public Mental Health System. If the consumer does not have MA, he/she must apply. We need a completed Individual’s Authorization form with the mental health provider listed if person/ agency completing the form is not the mental health provider. |
|  |  |
| 3. | Verify that consumer has applied for MA and provide a written statement acknowledging that he/she has applied; if he/she does not qualify please indicated why. |
|  |  |
| 4. | Indicate what type of coverage client has, if any. |
|  |  |
| 5. | Describe what assistance is needed and answer questions. If it is not for a necessity please explain how it would help with their mental health treatment. The Somerset CSA can provide assistance for security deposit, past due rent, past due mortgage payments, past due utilities, and utility deposits. We do not provide assistance for glasses, dental needs, clothing, and/or furniture. |
|  |  |
| 6. | If this is a reoccurring expense (ex. rent, utility) what were the circumstances that left the consumer unable to pay for the expense, and once caught up how they will be able to maintain paying. If this is a onetime only expense, explain why they are unable to pay for it themselves. |
|  |  |
| 7. | Please verify that other sources have been accessed for medications and provide a statement referencing the sources. A copy of the prescriptions must be included. |
|  |  |
| 8. | Explain why the $3.00 co-pay should be waived for each prescription requested. |
|  |  |
| 9. | Include all income in the household, not just the consumer’s. Include all expenses for the household. Provide evidence of all current household income and/or any current entitlement statements including food stamps. |
|  |  |
| 10. | Please make sure all members of the household are included in this section. |
|  |  |
| 11. | Indicate who the check should be made payable and their contact information. This cannot be the consumer. An Individual’s Authorization form must also be completed for this business or person allowing us to discuss payment. If requesting prescription assistance, we use Apple Discount Drug to fill most prescription (call first if another pharmacy needs to be used); if requesting lab assistance, we use Quest Diagnostics. |
|  |  |
| 12. | It is required that the client must have tried to obtain funding from at least three other sources for their financial need (with exception to lab tests). |
|  |  |
| 13. | The agency representative completing this form must sign and print their name and agency name. |
|  |  |
|  |  |
|  |  |

Somerset Local Behavioral Health Authority/Core Service Agency

Consumer Support Form

Phone 443-523-1786 Fax 410-651-3189

**Complete this form and Individual’s Authorization form(s)**

1. Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M / F Race:\_\_\_\_\_\_\_\_\_ **Mental Health Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If consumer is a child, note parent/guardian’s name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Adults in Household (**list names**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Children in Household (**list names)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is individual presently a consumer of Public Mental Health Services? Yes \_\_\_ No\_\_\_

Mental Health Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has the consumer been in mental health treatment and are the compliant with appointments and treatment plan? (*Brief description*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the consumer have Medical Assistance? MA#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_ No\_\_\_\_

Has the consumer applied for Medical Assistance? Yes\_\_\_ No\_\_\_\_

Date of Application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the consumer have Medicare? Yes\_\_\_ No\_\_\_\_

Is the consumer uninsured (Gray Area) and registered as such in the PMHS? Yes\_\_\_ No\_\_\_\_

Gray Area identification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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\_\_\_\_

**Somerset County will only pay up to $500**

Total dollar amount requested: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide *specific* details as to why the consumer 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, foodstamps) | $ | 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** | **$** |

1. Check should be made payable to: (cannot be made payable to consumer)

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list all agencies that have been contacted and note reason for approval/refusal.

**Minimum of 3 required.**

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

**Agency Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#/Ext:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

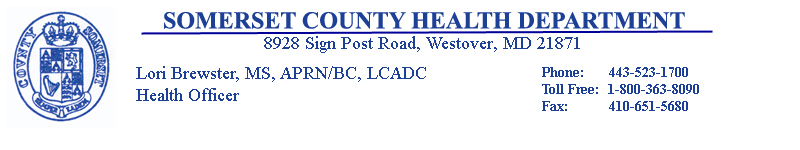
**Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 mental health (MH) provider, have you included a Release of information for the consumers MH 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 copy of the prescription(s) Note - CSA can only assist with psychotropic medication and tests for psychiatric purposes.)**
* **All sections of this application are completed in its entirety and supporting documentation is attached.**

CSA USE ONLY

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Approved |  | | | Amount |  | Denied | |  | | Date: |  |
| Comments: | | |  | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Signature: | |  | | | | | Signature: | |  | | |
|  | | Director / Health Department Designee | | | | |  | | CSA Coordinator | | |

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**AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION**

**Who is authorized to Receive and Use your health Information:**

# Name Address Phone Number

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - **Who is authorized to Disclose your health information**:

# Name Address Phone Number

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**Individual’s Health Information authorized for Use and Disclosure:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_\_\_\_

Present Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This Undersigned Hereby Requests And Authorizes That The Following Information be provided:**

**BCCP/Cancer** **Immunizations** **Prenatal**

**Communicable Diseases** **Laboratory Reports** **STD Records**

**Discharge Summary** **X-Ray Reports**

**Other (Specify)Contact Information/Risk Assessment**

**Except for the following which expressly may NOT be disclosed (if none, write “NONE”):**

**Check if this authorization is for psychotherapy notes. If for psychotherapy notes, Somerset County Health Dept. will not use this authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.**

**Purpose of Request, Why information is needed (optional):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If the information which the program has includes records or information from another entity, I \_\_\_ DO or \_\_\_ DO NOT wish to have that information released under this authorization.

Conditions For Exchange of Authorized Information

Expiration: This authorization will expire one year from 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 Consent Revoked by Client Signature of Client

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REDISCLOSURE: Any individual or agency receiving Somerset Co. Health Dept. 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 authorization is considered as effective and valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian or Legal Representative Date

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(attach copy of document granting legal authority)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Counselor (if applicable) Date

SCHD – Release v. 01/19