Instructions for completing the Somerset Local Behavioral Health Authority 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 the adult consumer and requested information should be written here.

2. Individuals 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 the person/ agency completing the form is not the mental health provider.
3. Verify that the consumer has applied for MA and provide a written statement acknowledging that he/she has applied; if he/she does not qualify please indicate why.
4. Indicate what type of coverage the 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 LBHA 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 recurring 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 one time 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. <u>This cannot be the consumer</u>. 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 prescriptions (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.

Consumer Support Form

Phone 443-523-1700 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)** ____

2. 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 they compliant with appointments and treatment plans? (*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 # ____________________________

3. 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: $________________________

Somerset County will only pay up to $500

4. 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, 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	**$**

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

Name: ________________________________

Address:________________________________

____

Telephone#________________________________

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

6. 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 in its entirely; 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 a copy of the prescription(s) Note - LBHA 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.**

LBHA USE ONLY

Approved ☒ Denied ☒ Amount: Date: Comments:

Signature:

Director/Somerset County Local Behavioral Health Authority

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

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: ____

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

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