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 TO RELEASE/RECEIVE INFORMATION

Use a separate form for each individual, program, organization or facility with which information may be shared. Please type or print as clearly and completely as possible.

1. **Patient Name** _____ **Date of Birth** _____

2. **I hereby authorize and request the following party to ⬜ release ⬜ receive information:**

_____
Name of individual, program, organization or facility

_____
address

3. **⬜ to ⬜ from the following party:** _____
Name of individual, program, organization or facility

_____
address

4. **The following information (INITIAL all items covered by this authorization):**

_____ **Acknowledgement of receipt of services**

_____ **Complete Program record (includes all items below):**

_____ Intake assessment _____ Treatment plan _____ Progress notes _____ Diagnosis
_____ History/Physical _____ Lab Results _____ Services/discharge summary
_____ Medications _____ Immunizations _____ Identifying Information
_____ Billing Records _____ Photographs, Video, Digital or other images
_____ Mental health _____ Records from other providers contained in the program record
_____ **Other (specify)** _____
_____

_____ **Alcohol or other drug treatment records (requires specific authorization). Specify below.**

_____ Complete record _____ Assessment results/history _____ Treatment/service plan progress/compliance

_____ Other (specify)_____

5. **The disclosure is for the following purpose(s) (Check all that apply):**
   - ⬜ Patient request
   - ⬜ Treatment/continued care
   - ⬜ Review current care
   - ⬜ Payment
   - ⬜ Insurance application
   - ⬜ Legal
   - ⬜ Other (please explain) _____

6. **This authorization expires one year from the date the form is signed unless I indicate an earlier date or event (must occur sooner than 1 year from the date of my signature) here:**

   Until Date: _____ **OR** Until specific event: _____

7. **I understand the following:**
   a. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.
   b. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.
   c. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.
   d. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.
   e. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

8. **Patient Signature** _____ **Date** _____

   Parent or Person Representative Signature *(if applicable)* _____ **Date** _____

   If signed by Parent or Personal Representative, please indicate Relationship to Patient

   - ⬜ Parent of Minor Child
   - ⬜ Guardian
   - ⬜ Authorized Representative
   - ⬜ Other _____

NOTICE

Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.

If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.