WORCESTER COUNTY CORE SERVICE AGENCY
FY 2018 REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR MEDICATION

Instructions:

1. This form is to be used to request payment by the Worcester County Core Service Agency for medication. Funds are available only to persons who reside in Worcester County. CSA funds are available for one time use only.

2. The referral party is the person making the request on behalf of the client and usually is the client's therapist, case manager, advocate or social worker. Applicant must verify the following:
   a. Individual is involved in the Public Behavioral Health System (PBHS);
   b. Medication is prescribed from a physician;
   c. Medication is a psychotropic medication OR a medication that supports the administration of a psychotropic medication;
   d. Individual has no personal financial resources to cover incurred expenses;
   e. Funds are not used to cover a co-pay or cover the Medicare "donut hole;"
   f. All other resources have been exhausted; **and**
   g. No charitable, or religious organizations, or individuals can assist.

3. Complete Section I, along with the attached release of information. Without a completed release, the application **cannot** be processed. Please ensure that a release is completed for any person, agency or organization that is involved with the assistance application, should the WCCSA need to contact them for additional information.

4. Fax the completed form and release(s) to the WCCSA for authorization at **410-632-0065**.

5. The WCCSA Director or designee will complete Section II and notify applicant of authorization or denial.

6. 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.

7. The WCCSA may require a co-payment or use of funds from other agencies in addition to WCCSA funding.

WORCESTER COUNTY CORE SERVICE AGENCY
FY 2018 REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR MEDICATION

Date of Request: _________________

SECTION I. To be completed by referral party

Client Name: ____ [ ] adult [ ] child/adol

Social Security Number: ___________________________DOB:____________________________________

Address: ____

Phone Number: __________________________________

Provider/Program Name: ____

Contact Person:__________________________________ Phone Number:_______________________________

Eligibility Criteria

1. Is the client in the Public Behavioral Health System? Yes________________ No________________

   ICD-10 Diagnosis: ____
2. Has the client received support from the CSA in the past? Yes_____________ No____________
   If yes, please provide date: _______________
3. Income and Benefits (List sources and amounts, i.e. TCA, MA, Medicare, SSI, etc.):_________________________

____

4. Please list at least **3** other sources that have been contacted for support and reason for denial:

   ____

   ____

5. Who verified client has no resources for medication coverage?

   ____

1. Has the client applied for Medical Assistance (Medicaid) ___________. If so, date of application:_____________.

   If Medicaid was denied, date of denial: ____.
2. Were samples available? ___________________ If Medicaid was denied, was assistance sought from the pharmaceutical company's patient assistance program?____
4. Applicant has called _________________________ Pharmacy (phone: ______________________) to determine cost of medication(s):

	Medication name:	Cost:	Generic	Brand
(1)	______________________________________	$____________________	[ ]	[ ]
(2)	______________________________________	$____________________	[ ]	[ ]
(3)	______________________________________	$____________________	[ ]	[ ]

TOTAL REQUEST: $__________________

Attach copy of the prescription(s) written by physician: If a generic version is available, ask for the generic instead of the brand name.

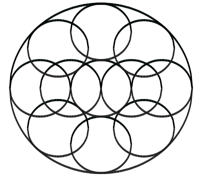
SECTION II: To be completed by the WCCSA Director/Designee

APPROVED: _____ *Amount:*____________ *Payable to* ____

DENIED: _____ *COMMENTS:* ____

*Signature of WCCSA Director/Designee:*____*Date:* _________

Revised 03/28/2017



Worcester County Core Service Agency
An Agency of the Worcester County Health Department
P.O. Box 249 ▪ Snow Hill, MARYLAND 21863-0249
410-632-3366 ▪ Fax: 410-632-0065

CONSENT TO *release/obtain* CONFIDENTIAL INFORMATION

In order to ensure continuity of care, I, ____

authorize Worcester County Core Service Agency to obtain information from ____________________

____

and release information to____

for the purpose of medication needs for wellness and stability.______________________________

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.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be obtained without my written consent unless otherwise provided for 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 (e.g. probation, parole, etc.) 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

SSN: ______________________ ____________________________________
Signature of Witness

PLEASE DIRECT ALL CORRESPONDENCE TO:

Worcester County Health Department
Core Service Agency
PO BOX 249
SNOW HILL, MD 21863

ATTENTION: _CORE SERVICE AGENCY____ SITE: _SNOW HILL______________________

Revised 06/28/2016