

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

Instructions:

1. This form is to be used to request payment by the Worcester County Core Service Agency for transportation services. 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. Transportation is needed to access PBHS sponsored mental health services;
 - c. Medical Assistance is unable to provide transportation for the individual;
 - d. Individual has no personal financial resources to cover incurred expenses
 - e. All other resources have been exhausted; **and**
 - f. 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.

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SECTION I. To be completed by referral party

Date of Request: _____

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

Social Security Number: _____ DOB: _____

Address: _____

Phone Number: _____

Provider/Program Name: _____

Contact Person and 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, SSI, etc.): _____

4. Who verified client has no resources for transportation arrangements?

5. Transportation is requested:

From: _____ To: _____ Date: _____

From: _____ To: _____ Date: _____

6. Transportation Provider: _____

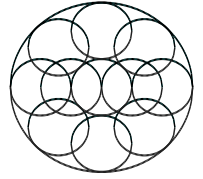
SECTION II: WCCSA Director/Designee

APPROVED: _____ DENIED: _____

COMMENTS: _____

Signature of WCCSA Director/Designee: _____ Date: _____

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 _____ transportation needs.

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:

- 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