WORCESTER COUNTY
LOCAL BEHAVIORAL
HEALTH AUTHORITY
Working together for healthier communities!

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY
FY 2019 REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR MEDICATION

Instructions:

1. This form is to be used to request payment by the Worcester County Local Behavioral Health Authority for medication. Funds are available only to persons who reside in Worcester County. LBHA 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 WCLBHA need to contact them for additional information.

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

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

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FY 2019 REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR MEDICATION

Date of Request: _____

SECTION I. To be completed by referral party

[ ] adult
Client Name: _____ [ ] 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 LBHA 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?

   _____
6. Has the client applied for Medical Assistance (Medicaid) _____. If so, date of application:_____.

   If Medicaid was denied, date of denial: _____.
7. Were samples available? _____ If Medicaid was denied, was assistance sought from the pharmaceutical company's patient assistance program? _____
8. 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 WCLBHA Director/Designee

APPROVED: _____ *Amount:*_____ *Payable to* _____

DENIED: _____ *COMMENTS:* _____

*Signature of WCLBHA Director/Designee:*_____*Date:* _____

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CONSENT TO *release/obtain* CONFIDENTIAL INFORMATION

In order to ensure continuity of care, I, _____

authorize Worcester County Local Behavioral Health Authority 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
Local Behavioral Health Authority
PO BOX 249
SNOW HILL, MD 21863

ATTENTION: _LOCAL BEHAVIORAL HEALTH AUTHORITY___