



WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY

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WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY FY 2019 REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

Instructions:

1. This form is to be used to request payment by the Worcester County Local Behavioral Health Authority (LBHA) for rent/utilities and other personal items/services. 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. Funds are being used to alleviate a problem;
 - c. Individual has no personal financial resources to cover incurred expenses
 - d. All other resources have been exhausted; **and**
 - e. 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). 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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RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

SECTION I. To be completed by referring 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 LBHA in the past? Yes _____ No _____

If yes, please provide date: _____

3. Number of children living in the home: _____

4. Number of roommates: _____ Is this request made on behalf of all roommates? _____

5. Indicate any Housing Programs client has received or applied for (Shelter Plus Care, Section 8, Rental Assistance, RRP): _____

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

7. If this is an educational expense, verify that this is part of their Service Plan and DORS funding is not available:

8. Describe the goods or services to be purchased on behalf of the client and the reason for the need.

9. Explain how the expenditure will assist the client in meeting his/her individual behavioral health treatment or rehabilitation goals. _____

10. Provide a specific plan indicating how the client intends on making payments in the future and prevent future need for emergency assistance. _____

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11. Please provide *all* monthly income and expenses:

Monthly Household Income:	Monthly Household Expenses:
Wages: \$ _____	Rent: \$ _____
SSI/SSDI: \$ _____	Electric/Gas: \$ _____
Child Support: \$ _____	Phone: \$ _____
Other*: \$ _____	Transportation: \$ _____
Total: \$ _____	Cable: \$ _____
	Food*: \$ _____
	Other: \$ _____
	Total: \$ _____

**Do not include food stamp allotment as income or food paid for by food stamps as an expense*

12. Attach an itemized quote or invoice from the vendor that verifies/explains the cost for the goods/services.

\$ _____ Total cost of goods/Services

\$ _____ Amount to be paid by client (If zero, requester certifies client cannot afford payment)

\$ _____ Amount to be paid by sources other than LBHA

\$ _____ Amount of vendor discount, if any

\$ _____ **Amount Requested from Local Behavioral Health Authority**

13. Vendor Information:

Name: _____

Address: _____

Telephone: _____ Date vendor must receive payment: _____

If approved, make check payable to _____ Fed ID# _____

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

APPROVED: _____ Amount: _____ Payable to _____

DENIED: _____ COMMENTS:

Signature of WCLBHA Director/Designee: _____ Date: _____

BHA Authorization (if over \$1000)

Signature of BHA Director of Adult Services or Child/Adolescent Services: _____ 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 payment arrangements for: _____.

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
Local Behavioral Health Authority
PO BOX 249
SNOW HILL, MD 21863**

ATTENTION: Worcester County Local Behavioral Authority