# WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY

## FY 2020 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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## FY 2020 REQUEST FOR FINANCIAL ASSISTANCE FOR
## RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

**SECTION I. To be completed by referring party**

*Date of Request:*___________________________

[ ] adult
Client Name: ___________________________________________________________ [ ] 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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**FY 2020 REQUEST FOR FINANCIAL ASSISTANCE FOR**

**RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES**

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

**Monthly Household Income:**

Wages: $______________________________

SSI/SSDI: $____________________________

Child Support: $________________________

Other*: $______________________________

**Total:** $______________________________

**Monthly Household Expenses:**

Rent: $___________________________________

Electric/Gas: $______________________________

Phone: $___________________________________

Transportation: $ __________________________

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:* ________



Revised 6/21/19

**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:

___**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: _Worcester County Local Behavioral Authority____



Revised 6/21/19