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

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY
FY 2020 REQUEST FOR LABORATORY SERVICES

Instructions:

1. This form is to be used to request payment by the Worcester County Local Behavioral Health Authority for laboratory 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. Lab work must be related to the individual's Behavioral illness;
   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 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.

WORCESTER COUNTY LOCAL BEHAVIORAL HEALTH AUTHORITY
FY 2020 REQUEST FOR FINANCIAL ASSISTANCE FOR LABORATORY SERVICES

Date of Request: _____

SECTION I. To be completed by referral party [ ] adult
Patient Name: _____ [ ] child/adol

Social Security Number: _____DOB:_____

Address: _____

Phone Number: _____Parent/Guardian *(if applicable)* _____

Provider/Program Name: _____

Contact Person:_____

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 amounts and sources, e.g. TCA, MA, Medicare, SSI, etc.):_____

   _____
4. Who verified client has no resources for lab testing? _____
5. Reason for lab testing:_____

_____

_____

Test/Profile	**Cost**
_____	_____
_____	_____

SECTION II: WCLBHA Director/Designee

APPROVED: _____ *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 lab 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:

__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_