Public Health
Prevent. Promote. Protect.
Somerset County Health Department

**Somerset County Health Department**
8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 • Fax 410.651.5680 • TDD 1-800-735-2258

Health Officer Danielle Weber, MS, RN

# Instructions for completing the Somerset Local Behavioral Health Authority Consumer Support Form and Authorization for the Release of Confidential Information Form

**<u>Consumer Support form:</u> Sections are numbered to allow for easier explanation of what is required. The request will be returned if all applicable sections are not completed.**

<u>*Only heads of household are eligible to apply for consumer support funds*</u>

**Section 1**: Consumer and household information must be completed in this section.

**Section 2:** Individual must be a consumer of the Public Mental Health System.

- An Authorization for Release of Confidential Information form for consumer's mental health provider must be completed if the person/ agency completing the form is not the mental health provider.
- If the consumer does not have medical assistance (MA), he/she must apply.
- Verify that the consumer has applied for MA and provide a written statement acknowledging that he/she has applied, if he/she does not qualify please indicate why.
- Indicate what type of coverage the client has, if any.

**Section 3:** Describe what assistance is needed and answer all questions. If assistance requested is not for a necessity, please explain how this would help with their mental health treatment.

- The Somerset LBHA can provide assistance for security deposit, past due rent, past due mortgage payments, past due utilities, and utility deposits. We do not provide assistance for glasses, dental needs, clothing, and/or furniture.

**Section 4**: If this is a recurring expense (ex. rent, utility) please explain the circumstances that left the consumer unable to pay for the expense, and once caught up, please explain how they will be able to maintain paying. If this is a one-time only expense, explain why consumer is unable to pay.

- **If a medication request**: please verify that other sources have been accessed for medications and provide a statement referencing the sources. A copy of the prescriptions must be included.
- Include all household income, not just the consumer's income.
- If requesting prescription assistance, we use Apple Discount Drug to fill most prescriptions (call first if another pharmacy needs to be used); if requesting lab assistance, we use Quest Diagnostics.
- Include all expenses for the household. Provide evidence of all current household income and/or any current entitlement statements including food stamps.

**Section 5:** Indicate to whom the check should be made payable and include contact information - **payee cannot be the consumer.** If payment request is for rent, a W-9 must be included.

**Section 6:** It is required (with exception of lab tests) that the client must have tried to obtain funding from at least three other sources for their financial need. Complete checklist in this section.

**<u>The agency representative completing this form must sign and print *their* name and *agency* name.</u>**

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**An <u>Authorization for the Release of Confidential Information</u> form must also be completed for the payee (business or person receiving payment) allowing us to discuss payment.**

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# Consumer Support Form

*****Only heads of household are eligible to apply for consumer support funds*****

Complete this form **and** individual's *Authorizations for Release of Confidential Information* and **submit to Sharon Creasy at sharonr.creasy@maryland.gov**

*(Please read Consumer Support Form instructions before completing)*

**Phone:** 443-523-1700 | **Fax:** 410-651-3189

**1.** Consumer Name: _____ DOB: _____ SSN: _____

Sex: M ☐ F ☐ Race: _____ Mental Health Diagnosis: _____

Address: _____ Phone #: _____

City/State/Zip: _____ County: _____

Number of Adults in Household: _____

List names: _____

_____

Number of Children in Household: _____

List names: _____

_____

**2**. Is individual presently a consumer of Public Mental Health Services? Yes ☐ No ☐

Mental Health Provider: _____

How long has the consumer been in mental health treatment? Are they compliant with appointments and treatment plans? Please provide a brief description.

_____

_____

Does the consumer have Medical Assistance? Yes ☐ No ☐

**If yes,** MA#_____

**If no**, has the consumer applied for Medical Assistance? Yes ☐ No ☐

Date of Application: _____

If ineligible for MA, please explain: _____

Does the consumer have Medicare? Yes ☐ No ☐

Is the consumer uninsured (Gray Area) and registered as such in the PMHS? Yes ☐ No ☐

**If yes,** Gray Area identification # _____

**3.** What assistance is being requested? Please provide brief description of assistance needed:

_____

_____

_____

Is the individual (household) capable of paying for this item(s)? Yes ☐ No ☐

Is there any other resource that could have paid for this item(s)? Yes ☐ No ☐

**Total amount requested: $_____** (***Somerset County will pay up to $1,000)***

**4.** Provide <u>specific</u> details as to why the consumer is unable to cover cost(s) themselves <u>and</u> how they plan to budget for this need in the future:

_____

_____

_____

_____

Please note all income and monthly expenses, documenting need for financial assistance. Income **MUST** exceed expenses or application will be denied.

| **Total Monthly Household Income:** | | **Expenditures:** | |
|---|---|---|---|
| Wages | $ | Rent/mortgage | $ |
| Assistance: SSI, SSDI, TDAP, TCA, food stamps, etc. | $ | Electric | $ |
| Other income: child support, financial aid, rental income, etc. | $ | Gas/propane/heating | $ |
| **Total** | **$** | Phone/cell | $ |
| | | Food stamps | $ |
| | | Food cost (other than food stamps) | $ |
| | | Water bill | $ |
| | | Transportation (car payment/ insurance, bus, taxi) | $ |
| | | Cable/internet | $ |
| | | Other | $ |
| | | **Total** | **$** |

**5.** Check payment information:

**<u>Checks can only be made payable to a business providing services to the consumer</u>**

Payee Name: _____

Payee Address: _____

City/State/Zip: _____ Phone: _____

**6.** Please list all agencies that have been contacted and note reason for approval/refusal. **Minimum of 3 required**.

| Agency Name | Contact Person | Phone Number | Reason Denied |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**Please ensure checklist is complete before submitting application: (mark box with a check)**

☐ A <u>separate</u> release of information for each agency/business will need to be completed in its entirety so the LBHA can call to discuss the application.

☐ If you are not the mental health (MH) provider, have you included a release of information for the consumer's MH provider?

☐ Have you included a copy of the utility bill, past due rent notice, or eviction papers? <u>For rent payments, a W-9 must also be included</u>

☐ Have you included evidence of all monthly household income (paystubs, SSI, or other type of benefit letter)?

☐ Have you included a copy of the prescription or lab request if applicable?

☐ If requesting Pharmacy Assistance, please provide a copy of the prescription(s).
**LBHA can only assist with psychotropic medication and tests for psychiatric purposes*

☐ All sections of this application are completed in its entirety and supporting documentation is attached.

**<u>*Email completed form to Sharon Creasy: sharonr.creasy@maryland.gov*</u>**

**Agency Name: _____ Phone #/Ext: _____**

**Representative Name: _____ Fax #: _____**

**Agency Representative Signature: _____ Date: _____**

**<u>LBHA USE ONLY</u>**

Approved ☐ Denied ☐

Date: _____

Amount: $_____

Comments: _____

_____

_____

**Signature**: _____

Director/Somerset County Local Behavioral Health Authority

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# Consumer Support Application Checklist

**Please provide the following information, along with the Consumer Support Application, to:**
**Somerset County LBHA, attention: Sharon Creasy**
**sharonr.creasy@maryland.gov**

- ☐ **Completed Application**
- ☐ **Authorization to release/receive confidential information** for Somerset County LBHA and Somerset County Health Department: must be signed and dated (needed to discuss application with worker)
- ☐ **Multiple authorizations** to release/receive information for the landlord/utility company or other businesses and the Somerset County LBHA: must be signed and dated (needed to discuss clients' needs and what we need from the company/landlord or others to process the application)
- ☐ **Treatment plan with goals from provider:** this is a requirement set by the Behavioral Health Administration to support the need of the request and proves the client is actively in treatment
- ☐ **Documentation from three other resources/businesses/churches** where funds were requested by client or worker (letters, emails, copy of receipts of payment)
- ☐ **Income:** attach income documentation for client and all household sources, including other household member's income (wages, SSI/SSDI/SS, child support, alimony, SNAP, TCA, etc.)
- ☐ **Lease/Mortgage:** needed if requesting housing assistance; the lease must be current/ valid (not expired)
- ☐ **W9 Form:** the W9 must include business name, address, type of business, Federal Tax ID Number or Social Security Number (must be signed and dated by the authorized person at the place of business)
- ☐ **Bill or Statement:** bill/statement should reflect what is currently owed on the client's account (must be signed and dated by the landlord/business)
- ☐ **Receipts/Canceled Checks:** include copies of receipts from client if they paid a portion of the expense and documentation from the other churches/businesses that contributed to the financial request

*Applications for additional services can be found on the Somerset County Health Department website: somersethealth.org/behavioral-health/program-services*

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## AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

*Use a separate form for each individual, program, organization or facility with which information may be shared. Please type or print as clearly and completely as possible.*

1. **Patient Name** _____ **Date of Birth** _____

2. **I hereby authorize and request the following party to ⬜ release ⬜ receive information:**

_____
Name of individual, program, organization or facility

_____
address

3. **⬜ to ⬜ from the following party:** _____
Name of individual, program, organization or facility

_____
address

4. **The following information (INITIAL all items covered by this authorization):**

_____ **Acknowledgement of receipt of services**

_____ **Complete Program record (includes all items below):**

_____ Intake assessment _____ Treatment plan _____ Progress notes _____ Diagnosis
_____ History/Physical _____ Lab Results _____ Services/discharge summary
_____ Medications _____ Immunizations _____ Identifying Information
_____ Billing Records _____ Photographs, Video, Digital or other images
_____ Mental health _____ Records from other providers contained in the program record
_____ **Other (specify)** _____
_____

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_____ **Alcohol or other drug treatment records (requires specific authorization). Specify below.**

_____ Complete record _____ Assessment results/history _____ Treatment/service plan progress/compliance

_____ Other (specify)_____

5. **The disclosure is for the following purpose(s) (Check all that apply):**
   - ⬜ Patient request
   - ⬜ Treatment/continued care
   - ⬜ Review current care
   - ⬜ Payment
   - ⬜ Insurance application
   - ⬜ Legal
   - ⬜ Other (please explain) _____

6. **This authorization expires one year from the date the form is signed unless I indicate an earlier date or event (must occur sooner than 1 year from the date of my signature) here:**

   Until Date: _____ **OR** Until specific event: _____

7. **I understand the following:**
   a. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.
   b. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.
   c. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.
   d. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.
   e. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

8. **Patient Signature** _____ **Date** _____

   **Parent or Person Representative Signature** *(if applicable)* _____ **Date** _____

   **If signed by Parent or Personal Representative, please indicate Relationship to Patient**

   - ⬜ Parent of Minor Child
   - ⬜ Guardian
   - ⬜ Authorized Representative
   - ⬜ Other _____

**NOTICE**

**Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.**

**If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.**

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.