



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

**Maryland RecoveryNet (MDRN)
Substance Use Disorder (SUD)
Client Support Services**

Phone 443-523-1700 Fax 410-651-3189

Complete this form and Individual's Authorization form(s)

1. Client Name: _____ DOB: _____ SS#: _____

Sex: M / F Race: _____ **Substance Use Diagnosis:** _____

Address: _____ Phone #: _____

_____ County: _____

of Adults in Household (**list names**) _____

of Children in Household (**list names**) _____

2. Is the individual presently a State Care Coordination Client? Yes ___ No ___

3. Is the individual presently a Client of the Public Behavioral Health System? Yes ___ No ___

Substance Abuse Health Provider: _____

How long has the Client been in substance abuse treatment and are they compliant with appointments and treatment plan? (*Brief description*)

Does the Client have Medical Assistance? MA# _____ Yes ___ No ___

Has the Client applied for Medical Assistance? Yes ___ No ___

Date of Application _____

Does the Client have Medicare? Yes ___ No ___

Is the Client uninsured (Gray Area) and registered as such in the PBHS? Yes ___ No ___

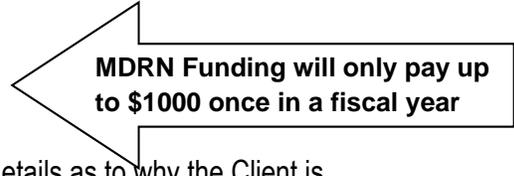
Gray Area identification # _____

4. 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 dollar amount requested: \$ _____



5. If Client is requesting coverage of a recurring cost, provide specific details as to why the Client is unable to cover cost(s) themselves and 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.

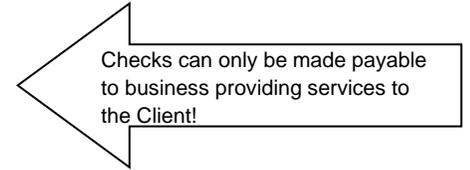
Total Monthly Household Income:		Expenditures:	
Wages	\$	Rent	\$
Assistances (SSI, SSDI, TDAP, TCA, food stamps)	\$	Electric	\$
Other: (child support, financial aid, rental income)	\$	Gas/propane/heating	\$
Total	\$	Phone/cell	\$
		Food Stamps	\$
		Food cost (other than food stamps)	\$
		Water Bill	\$
		Transportation (car payment/insurance, bus, taxi)	\$
		Cable/Internet	\$
		Other	\$
		Total	\$

6. Check should be made payable to: (cannot be made payable to Client)

Name: _____

Address: _____

Telephone # _____



7. Please list all agencies that have been contacted and note reasons for approval/denial.

Minimum of 3 required.

Agency Name:	Contact Person:	Telephone #:	Reason Denied:
1.			
2.			
3.			

Agency Representative Signature: _____ Date: _____

Print Name: _____ Phone#/Ext: _____

Agency Name: _____ Fax #: _____

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

- A separate Release of information for each agency/business will need to be completed so the LBHA can call to discuss the application.
- If you are not the substance abuse (SUD) provider, have you included a Release of information for the Clients Treatment provider?
- Have you included a copy of the utility bill, past due rent notice or eviction papers?
- 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) Note - LBHA can assist with behavioral health disorder medication which supports the administration of a medication related to a behavioral health disorder.
- All sections of this application are completed in its entirety and supporting documentation is attached.
- Have you included a copy of the individual's treatment or recovery plan?

LBHA USE ONLY

Approved Amount _____ Denied Date: _____

Comments: _____

Signature: _____ Signature: _____
Director / Health Department Designee LBHA Coordinator



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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) _____ | | | |

_____ 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):

- | | | |
|---|---|--|
| <input type="checkbox"/> Patient request | <input type="checkbox"/> Treatment/continued care | <input type="checkbox"/> Review current care |
| <input type="checkbox"/> Payment | <input type="checkbox"/> Insurance application | <input type="checkbox"/> Legal |
| <input type="checkbox"/> 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 _____ **Date** _____
Signature (if applicable)

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

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Parent of Minor Child | <input type="checkbox"/> Guardian | <input type="checkbox"/> Authorized Representative |
| <input type="checkbox"/> 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.