Wicomico/Local Behavioral Health Authority/LBHA
Client Support Form

Phone 410-543-6981 Fax 410-219-2876 wicomico.lbha@maryland.gov

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

Applicant must be 18 years of age or older.

Please ensure checklist is complete before submitting application:

*** Please note that applications submitted by clients will not be reviewed ***

- ☐ **Income MUST exceed expenses or application will be denied.**
- ☐ **Client must have Medical Assistance or be uninsured. Private insurance is not accepted.**
- ☐ **A separate Individual Authorization form for each agency/business will need to be completed so the LBHA can call to discuss the application.**
- ☐ **If you are not the mental health (MH) provider, have you included an Individual Authorization form for the clients MH provider?**
- ☐ **Have you included a copy of the bill that is past due or that you need assistance with paying?**
- ☐ **Have you included evidence of all monthly household income (most recent 30 days 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 copy of the prescription(s) Note- LBHA can only assist with psychotropic medication and tests for psychiatric purposes.)**

All sections of this application must be completed in its entirety and supporting documentation attached.

Behavioral Health Representative Acknowledging Completion:

Signature: _____ **Date:** _____

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Client Name: _____ DOB:_____ Age:_____

Address: _____ Phone #: _____

_____ County:_____

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

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

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1. 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 and registered as such in the PMHS? Yes___ No___

Uninsured identification # _____

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2. Is the individual presently a client of Public Mental Health Services*? Yes ___ No___

Client must NOT have private insurance

Mental Health Provider: _____

Mental Health Diagnosis: _____

Has the client been in mental health treatment and are they compliant with appointments and treatment plans? Yes ___ No___

Date of last appointment: _____ Date of next appointment: _____

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3. What type of assistance is being requested?

☐ Rent / Security Deposit ☐Utility ☐ Other:_____

4. Has the client received assistance from us in the past 12 months? ☐ Yes ☐ No

If yes, provide date if known:_____

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5. Share why the client is unable to cover cost(s) themselves.

_____

_____

6. How do they plan to budget for this need in the future?

_____

_____

7. 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:		**Total Monthly Expenditures:**	
Wages	$	Rent	$
SSI, SSDI	$	Electric	$
TDAP	$	Gas / Propane / Heating	$
TCA	$	Phone/Cell	$
SNAP (Food Stamps)	$	SNAP (Food Stamps)	$
Child support	$	Groceries (other than food stamps)	$
Other:	$	Water Bill	$
Other:	$	Car Payment / Insurance)	$
		Cable / Internet	$
		Other	$
Total	**$**	**Total**	**$**

Revised 8/2023

8. Total dollar amount requested: $_____

**For balances over $1,000, a commitment letter from any contributing agency must be provided.*

9. Check should be made payable to: (cannot be made payable to client)

Name: _____

Address: _____

_____

Telephone #_____

10. Please list all agencies that have been contacted and note reasons for approval/refusal.

Minimum of 3 required.

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

11. Behavioral Health Representative Assisting Client:

Print Name: _____ **Agency Name:** _____

Email: _____

Phone#/Ext: _____ **Fax #:** _____

LBHA USE ONLY

Approved	☐	Amount		Denied	☐	Date:	
Comments:							
Signature:				Signature:			
	Director / Health Department Designee				LBHA Staff		

Revised 8/2023

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

Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

Matthew McConaughey, MPH, Health Officer

Accredited Health Department • PHAB Advancing Public Health Performance • Public Health Accreditation Board

INDIVIDUAL'S AUTHORIZATION

THIS FORM IS USED TO CONFIRM THE DIRECTION OF AN INDIVIDUAL TO AUTHORIZE THE WICOMICO COUNTY HEALTH DEPARTMENT TO ☐ REQUEST, TO USE, AND/OR TO ☐ DISCLOSE THE INDIVIDUAL'S HEALTH INFORMATION.

PLEASE TYPE OR PRINT NEATLY; WE ARE NOT ABLE TO PROCESS INCOMPLETE OR ILLEGIBLE FORMS.

☐ **CHECK IF THIS AUTHORIZATION IS FOR PSYCHOTHERAPY NOTES.**

IF THIS AUTHORIZATION IS FOR PSYCHOTHERAPY NOTES, WICHD WILL NOT USE IT AS AN AUTHORIZATION FOR ANY OTHER TYPE OF HEALTH INFORMATION. IF THE INDIVIDUAL SEEKS TO AUTHORIZE THE USE AND DISCLOSURE OF OTHER HEALTH INFORMATION AS WELL, AN ADDITIONAL FORM MUST BE SUBMITTED.

SECTION A: INDIVIDUAL'S HEALTH INFORMATION AUTHORIZED FOR USE AND DISCLOSURE.

Last Name_____ **Middle:** _____ **First:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (Home): _____ **DOB:** _____ **PT ID:** _____

SECTION B: THE USE AND/OR DISCLOSURE BEING AUTHORIZED: PROVIDE A DETAILED DESCRIPTION OF THE HEALTH INFORMATION; YOU ARE AUTHORIZING US TO USE AND/OR DISCLOSE.

I.) Provide Financial Assistance/Continuity of Care_____

WHO IS AUTHORIZED TO x DISCLOSE x RECEIVE AND USE YOUR HEALTH INFORMATION?

Wicomico Behavioral Health Authority

108 E. Main St.

Salisbury, MD 21801 410-543-6981

WHO IS AUTHORIZED TO x DISCLOSE x RECEIVE AND USE YOUR HEALTH INFORMATION?

INDIVIDUAL'S AUTHORIZATION (CONTINUED)

OTHER:

_____

_____

_____

If the information which the program has includes records or information from another entity,
I ☐ do or ☐ do not wish to have that information released under this authorization.

SECTION C: EXPIRATION AND REVOCATION.

(If this section is not completed, WiCHD cannot accept this form.)

This authorization will expire (complete one):

☐ ON _____

☐ ON OCCURRENCE OF THE FOLLOWING EVENT (WHICH MUST RELATE TO THE INDIVIDUAL OR TO THE PURPOSE OF THE USE AND/OR DISCLOSURE BEING AUTHORIZED): _____

Right to Revoke: *I understand that I may revoke this authorization at any time by giving written notice of my revocation to WiCHD. In order to obtain a revocation form to revoke this authorization, I understand that I may contact the office of the WiCHD Health Officer/Deputy Health Officer. I understand that revocation of this authorization will not affect any action that WiCHD or others named or unnamed took in reliance on this authorization before WiCHD received my written notice of revocation.*

SECTION D: SIGNATURE

I authorize the use and/or disclosure of my health information as described in section B above. I understand this authorization is voluntary.

I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. If the request for information concerns treatment of alcohol or other substance abuse, the confidentiality of the information is protected by federal law 42 CFR Part 2. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Signature: _____ **Date:** _____

If a personal representative is making this request, a copy of any document granting legal authority is required. Complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Public Health
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