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

Homeless Identification and Birth Certificate Project
Instructions to Make a Referral

PURPOSE: Program provides funding for birth certificates and/or State Identification/DriversLicense renewals.

ELIGIBILITY: To qualify, the individual must be experiencing homelessness or is at imminent risk of becoming homeless, and have a mental illness or co-occurring substance use disorder.
Minor children in the care of a qualifying adult that meets the homeless and disability criteria are also eligible for birth certificates.

INSTRUCTIONS TO MAKE A REFERRAL:

1. Verify individual meets the following requirements:
    a. Is age 18 or older OB If the individual is under age 18, they must be in the care of an adult that meets criteria below
    b. Has a mental illness or co-occurring substance use disorder
    c. Currently homeless or at imminent risk of becoming homeless
    d. The individual may not have requested funds from this project within the past 5 months
    e. Individual is eligible for services within the public mental health system
2. Complete the application packet with the individual. Application includes the following:
    a. The **"Behavioral Health Administration Homeless I.D.Project FY 2018 Application/Intake'.**
    b. The **"Maryland Homeless I.D. Project Documentation of Homelessness'**. This is a self-verification of homelessness completed by the individual (including current situation, how long they have experienced homelessness, how many episodes of homelessness, what makes them at risk of homelessness, etc.). ***If the individual is currently staying in a shelter, please include a letter from the shelter.**
    c. The **"Wicomico Behavioral Health Authority Consent to release/obtain Confidential Information'**. Complete two consent forms, one for referring agency and the second one for Help Outreach Point of Entry (H.O.P.E.). This gives permission for information regarding your Homeless I.D. referral to be shared between our agencies

3. If the individual applying is currently incarcerated, include a complete and notarized **"Maryland Power of Attorney'** form and the second section of the Maryland Birth Certificate Application needs to be filled out. This gives H.O.P.E. the ability to purchase a Maryland birth certificate on the applicant's behalf while they are incarcerated.

4. Submit the application packet either by fax or mail to:
    Wicomico Behavioral Health Authority
    108 E. Main St.
    Salisbury, MD 21826
    Telephone: (410) 543-6981
    Fax: (410) 219-2876

BEHAVIORAL HEALTH ADMINISTRATION

Homeless I.D. Project APPLICATION/ INTAKE

Client Name: _____D.O.B.* _____Phone number: _____

*If Client is under age 18, is he/she under the care of an adult that is homeless/imminent risk of homelessness AND has a mental illness or co-occurring substance use disorder: ___Yes ___No

Client MA #, Gray Zone # or Medicare #:_____ Social Security #_____

Current Living Situation: __ Emergency Shelter __Transitional Housing __Hospital __ Hotel/Motel

__ Jail ___Street, Park, Car, Bus Station, Bridge, etc. ___Living with Relatives/Friends

Other: _____ Zip Code of Last residence: _____

Chronically Homeless (homelessness for a year or longer, or at least four episodes of homelessness in the last three years): ___Yes ___No

Housing Status: ___Literally Homeless ___Imminently Losing Housing

Veteran: ___Yes __No Gender: __ Male __ Female Race:_____ Ethnicity:_____

Disability: Mental Illness _____ Co-occurring_____

Person completing form: _____ Phone #_____

Agency & Address: _____

Documentation of Homelessness Received: ____ Yes ____ No

*WBHA will maintain file applications

Request: (Please check all that apply)

____ State Identification Card ***OR*** ____ Drivers License Renewal

____ Birth Certificate Which state: _____

FOR WBHA OFFICE USE ONLY: **Provider Making the Request**: _____

Requesting WBHA has verified that this is not a duplicate request for funding for this individual within the past 6 months: ___Yes ___ No *Note: There is a **maximum of 2** IDs or Birth Certificates

FOR ID:

Check payee:_____

AMOUNT: _____

Phone #:_____

Payee address:_____

Tax ID #:_____

Account # if applicable: _____

For Birth Certificate:

Check payee:_____

AMOUNT: _____

Phone #:_____

Payee address:_____

Tax ID #:_____

Account # if applicable: _____

Total Amount Approved by WBHA: _____ Amount Denied by WBHA _____

_____ _____

Approved WBHA Director or Designee Date

_____ _____

WBHA Fiscal Officer Date Approved YTD _____

Date ID paid: _____

Date Birth Certificate Paid: _____

Revised 4/10/18

BIRTH Application for Certified Copy of Maryland Birth Record BIRTH

Maryland Department of Health and Mental Hygiene • Division of Vital Records

Photo identification provided **Receipt # BR2023_____ Certificate #: _____**

By my signature below, I state that I am the person I represent myself to be herein, and I affirm that the information submitted on this form is complete and accurate and submitted subject to the criminal penalties set forth at Maryland Code Annotated, Health-General Section 4-227.

Signature of person making request: _____

Date of Application: _____

NOTE: A copy of a birth record may only be issued to the person named on the Certificate; a parent or court-appointed guardian; a representative with a notarized letter signed by the person named on the Certificate, a parent or guardian granting permission to obtain a Certificate; an individual with a court order directing that the Certificate be issued; or an individual permitted to obtain a certificate under Md. Code Ann., Family Law Title 5, Subtitles 3A or 4B relating to adoptions.

PRINT your name & CURRENT address.

Name: _____ Your relationship to the person named on the Certificate: _____
(First) (Middle) (Last)

Address: _____

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

Daytime phone number: (_____) _____-_____

PHOTO ID REQUIRED: The individual requesting the record should submit a legible copy of his/her VALID U.S. GOVERNMENT-ISSUED PHOTO ID with completed application. (Examples: State issued driver's license or non-driver photo ID with requestor's current address; U. S. passport). If you do not have a U. S. Government-issued photo ID, read and sign the following statement: I declare that I do not have a government-issued photo ID and that I am presenting the attached two documents that include my name and current address as proof of identification. ***(Note: These documents must include two of the following: Utility bill, car registration form, pay stub, bank statement, copy of income tax return/W-2 form, letter from a government agency requesting a vital record, or lease/rental agreement. Please submit photocopies since these documents will not be returned to you. If you do not have a Government-issued photo ID, the certificate(s) will be mailed to the address listed on the documents that you present.)***

Signature: _____

PRINT information below with regard to the individual named on the requested certificate:

Fill out only

Name at Birth: _____

If name has changed since birth due to adoption, court order, or any reason other than marriage, please list new name here: _____

Date of Birth: _____ **Current age:** _____ **Sex: (Circle One): Male Female**
(Month/Day/Year)

Place of Birth: _____ **Hospital:** _____ County: _____
(City)

Full Maiden Name of Mother: _____
(Name she was born with)

Full Name of Father: _____

Number of Copies you want ($22.00 Each) _____

ORDER INFORMATION

You may also apply for a birth record on line, by telephone or by fax. For further information, visit the Vital Statistics Administration website at http://www.vsa.state.md.us/vsa/html/apps.html.

*There is no fee for: A copy of a certificate of a current or former armed forces member that is requested by the member. Proof of service in the armed forces must be provided.

Vital records verification _____ ***Vital records verification*** _____

Birth records filed over 100 years ago are available through the Maryland State Archives in Annapolis (telephone number 410-260-6400).

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For Maryland Birth Certificate

Date: _____

I, _____, give

Hope Inc._____ permission to obtain my

Birth Certificate from Wicomico County Health Department.

_____

(Applicant's Signature here).

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF MARYLAND

COUNTY OF _____

This document was acknowledged before me on _____ (Date) by
_____ (name of principal)

(Notary Seal, if any)

_____
(Signature of Notarial Officer)
Notary Public for the State of Maryland
My commission expires: _____

MARYLAND
Department of Health

MARYLAND HOMELESS I.D. PROJECT

Documentation of Homelessness

Please use the following space to describe the applicant's current living situation. If the applicant is currently in the detention center, please describe their living situation prior to incarceration. If the applicant is currently residing in a shelter, transitional housing program, or other temporary housing facility additional documentation of homelessness, i.e. letter on agency letterhead must be included with this form.

Self-Verification (Brief statement from client saying he/she is homeless or at-risk of losing his/her housing):

_____

_____

_____

_____

_____

_____

_____

(Please ask the Applicant these questions):

1. Where do you typically stay at night? _____

2. Do you know the name of the shelter or housing program where you stay?

_____

3. Do you work with any of the outreach teams or case management programs? ____ Yes ____ No

If yes, do you know the name of the agency or the worker you see? _____

_____

I certify that the information provided regarding my homeless status is accurate and true.

Date: _____ **Signed:** _____ (Applicant)

Date: _____ **Witness:** _____

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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 IN ORDER TO OBTAIN BIRTH CERTIFICATE**_____

_____

_____

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: _____

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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?

_____

_____

_____

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