Wicomico Local Behavioral Health Authority
Medical Equipment/Services Assistance
Harm Reduction Funds

Phone: 410-543-6981 Fax: 410-219-2876

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

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

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

If consumer is a child, note parent/guardian's name and DOB: _____

Address: _____ Phone #: _____

_____ County:_____

Total dollar amount requested for medical equipment or services assistance: $_____

How did you find out about this assistance program?_____

Has MDRN (Maryland Recovery Net funds been used or exhausted? Please explain in detail.

_____

Total amount not to exceed more than $250 for glasses and/or $1,000.00 for dental work and glasses combined.

2. Is the individual presently a consumer of Public Behavioral Health Services (PBHS)? Yes ___ No___

Substance Abuse Provider:_____

Does the consumer have Private Insurance? Yes___ No____

Does the consumer have Medical Assistance? MA#_____ Yes___ No____

Has the consumer applied for Medical Assistance? Yes___ No____

Date of Application_____

Does the consumer have Medicare? Yes___ No____

Is the consumer uninsured (Gray Area) and registered as such in the PBHS? Yes___ No____

Gray Area identification # _____

What assistance is being requested? **Insurance must be used first.** Please provide brief description of assistance needed:

_____

_____

_____

3. Check should be made payable to: (cannot be made payable to consumer)

Name: _____

Address: _____

_____

Telephone #_____

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

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

Agency Name: _____ **Fax #:** _____

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

- ☐ **A separate Consent/ Release of information for each agency/business/housing program will need to be completed so the LBHA can call to discuss the application**
- ☐ **If you are not the substance abuse (SA) provider, have you included a Consent/Release of Information for the consumers SA provider?**
- ☐ **All sections of this application are completed in its entirety and supporting documentation is attached.**

LBHA USE ONLY

Approved ☐ Amount _____ Denied ☐ Date: _____

Comments: _____

_____

_____

_____

Signature: _____ Signature: _____

Director / Health Department Designee LBHA Coordinator

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

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.) **Continuity of Care**_____

_____

_____

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

Wicomico Behavioral Health Authority_____

108 E. Main St._____

Salisbury, MD 21801_____

WHO IS AUTHORIZED TO ☐ DISCLOSE ☐ 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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I.) **CONTINUITY OF CARE**_____

_____

_____

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

WICOMICO BEHAVIORAL HEALTH AUTHORITY_____

108 E. MAIN ST._____

SALISBURY, MD 21801_____

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

_____

_____

_____

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