

Wicomico Somerset Regional Core Service Agency Consumer Support Form
Client Special Need • Pharmacy • Laboratory
Phone 410-543-6981 Fax 410-219-2876

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

1 Consumer Name: _____ DOB: _____ SS#: _____
Address: _____ Phone #: _____
_____ County: _____

2 Is individual presently a consumer of Public Mental Health Services? Yes _____ No _____
Does the consumer have Medical Assistance? MA# _____ Yes _____ No _____
Has consumer applied for Medical Assistance and/or PAC? Yes _____ No _____
Date of application _____

3 Need proof of application or written statement that requestor knows for a fact that consumer has applied for MA and/or PAC. _____

4 Does the consumer have Medicare? Yes _____ No _____
Is the consumer uninsured (Gray Area) and registered as such in the PMHS? Yes _____ No _____
Gray Area identification number _____
Does the consumer have private insurance? Yes _____ No _____
Insurance Provider: _____ Insurance #: _____

5 What assistance is being requested? Please provide brief description of assistance needed and dollar amount requested such as: overdue electric bill - \$150.00; prescription assistance, list psychiatric medications and length of time assistance needed; lab tests needed, for psychiatric purposes _____

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: \$ _____ Date funding needed by: _____

6 Provide *specific* details as to why the consumer is unable to cover cost(s) themselves and what the plan is to pay for need in the future. _____

7 If requesting **Pharmacy Assistance** please **provide copy of the prescription(s)**, list other sources for medication(s) that have been accessed or/and denied (Salvation Army, Indigent Drug Programs, Med Bank). If there are no samples available please include a signed statement by the Psychiatrist/Therapist or Physician's office.

8 If requesting that the \$3.00 co-pay for each medication is waived, please explain why. _____

9 Please note *all* income and *all* monthly expenses, documenting need for financial assistance:

Monthly Household Income:	\$ _____	Expenses:	rent	\$ _____
(wages, disability income	\$ _____		electric/gas	\$ _____
SSI/SSDI, child support, other)	\$ _____		phone	\$ _____
	Total		cable	\$ _____
			food	\$ _____
10 # Adults in Household	_____		transportation	\$ _____
# Children in Household	_____		other	\$ _____
			Total	\$ _____

11 Check should be made payable to: (cannot be made payable to consumer)

Name: _____ (This business / person must be listed
Address: _____ on the Individual's Authorization form)

Telephone #: _____

12 Please list all agencies such as DSS and other charitable organizations that have been contacted and note reason for refusal. Minimum of two required.

Agency Name: _____	Agency Name: _____
Contact Person: _____	Contact Person: _____
Telephone #: _____	Telephone #: _____
Reason Denied: _____	Reason Denied: _____

13 Agency Representative Signature: _____ Date: _____
 Print Name: _____
 Agency Name: _____ Phone #: _____

CSA USE ONLY

Approved Amount _____ Denied Date: _____
 Comments: _____

Signature: _____ Signature: _____
 Director / Health Department Designee CSA Coordinator
 (Two Authorized Signatures are Required for Client Special Needs)



Wicomico County Health Department

108 East Main Street
Salisbury, Maryland 21801

410-749-1244
FAX: 410-543-6975
TDD: 410-543-6952

LORI BREWSTER, M.S., APRN/BC, LCADC
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.) WICOMICO SOMERSET REGIONAL CSA

ANY PERTINENT INFO

II.) _____

ANY PERTINENT INFO

THE PURPOSE OF THE DISCLOSURE:

I.) _____

II.) _____

WHO IS AUTHORIZED TO DISCLOSE YOUR HEALTH INFORMATION:

I.) WICOMICO SOMERSET REGIONAL CORE SERVICE AGENCY

108 E. MAIN ST SALISBURY, MD 21801
410-543-6981

II.) _____

WHO IS AUTHORIZED TO RECEIVE AND USE YOUR HEALTH INFORMATION:

I.) WICOMICO SOMERSET REGIONAL CORE SERVICE AGENCY

108 E MAIN ST. SALISBURY MD 21801

410-543-6981

II.)

**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.)

Expiration: 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: To the Individual – Please read the following.

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 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: _____