

## Wicomico Somerset Regional Core Service Agency Transportation Assistance Request Form

|   |                     |         |
|---|---------------------|---------|
| Transportation assistance is for <i>uninsured</i> consumers of public mental health services needing transportation to and from mental health appointments and/or service linkages (e.g., entitlements, housing, employment). |                     |         |
| Date:   | Consumer Name:      |         |
| Address:  |                     |         |
| SS#:  | DOB:                | County: |
| MA# or Medicaid Ineligible#:  | Telephone #:        |         |
| Monthly Income \$   | Monthly Expenses \$ |         |
| Is client an active consumer of Public Mental Health Services? <input type="checkbox"/> YES <input type="checkbox"/> NO   |                     |         |
| Reason for lack of transportation:  |                     |         |
|   |                     |         |
| Why is transportation needed?   |                     |         |
|   |                     |         |
| List other transportation resources accessed and if applicable, reason for denial of continued assistance:  |                     |         |
|   |                     |         |
| Length of time transportation will be needed, i.e. number of visits: (not to exceed one month)  |                     |         |

|   |        |                      |
|---|--------|----------------------|
| Please provide appointment information: <b>Date:</b>                            |        | <b>Pick Up Time:</b> |
| Transport from:   |        |                      |
|   |        |                      |
| Transport to:   |        |                      |
|   |        |                      |
| Will call for pick up? <input type="checkbox"/> YES <input type="checkbox"/> NO |        |                      |
|   |        |                      |
| Requestor:  | Phone: |                      |
| Agency:   |        |                      |

|  |  |
|--|--|
| <b>CSA USE ONLY</b>  |  |
| <input type="checkbox"/> Approved                              | <input type="checkbox"/> <u>NOT</u> Approved |
| # of transportation visits approved :                          |  |
| Co-pay amount, if applicable: (payable to Core Service Agency) |  |
| Comments:  |  |
|  |  |
|  |  |
| Authorized Signature:  | Date:  |



# 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.) SALISBURY TAXI

\_\_\_\_\_  
ANY PERTINENT INFO  
\_\_\_\_\_

**THE PURPOSE OF THE DISCLOSURE:**

I.) \_\_\_\_\_

II.) \_\_\_\_\_

**WHO IS AUTHORIZED TO DISCLOSE YOUR HEALTH INFORMATION:**

I.) WICOMICO SOMERSET REGIONAL CSA

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

II.) SALISBURY TAXI

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHO IS AUTHORIZED TO RECEIVE AND USE YOUR HEALTH INFORMATION:**

**I.) WICOMICO SOMERSET REGIONAL CSA**

108 E MAIN ST. SALISBURY MD 21801

410-543-6981

**II.) SALISBURY TAXI**

**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, WICHHD 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: \_\_\_\_\_