

**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 #: \_\_\_\_\_

**Please ensure checklist is complete before submitting application: (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



# Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

Matthew McConaughy, 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:

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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.*

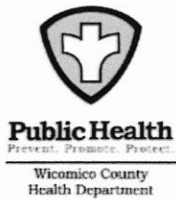
Signature: \_\_\_\_\_

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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