Homeless Identification and Birth Certificate Project
Instructions to Make a Referral

PURPOSE: Program provides funding for birth certificates and/or State Identification/Drivers License 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 ***OR*** 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***". This gives permission for your Homeless I.D. referral to be sent to the Wicomico Behavioral Health Authority for program monitoring.

3. 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

If you have questions please call the Wicomico Behavioral Health Authority

BEHAVIORAL HEALTH ADMINISTRATION

Homeless I.D. Project FY 2018 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:	For Birth Certificate:
Check payee:______________________________	Check payee:______________________________
AMOUNT: ______________________________	AMOUNT: ______________________________
Phone #:________________	Phone #:________________
Payee address:______________________________	Payee address:______________________________
Tax ID #:______________________________	**Tax ID #:**______________________________
Account # if applicable: ______________________	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

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):

____

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(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:** ____

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.) INFORMATION NEEDED TO PROVIDE FINANCIAL ASSISTANCE

THE PURPOSE OF THE DISCLOSURE:

I.) PROVIDE FINANCIAL ASSISTANCE IN ORDER TO OBTAIN I.D. OR BIRTH CERTIFICATE

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

WICOMICO CO. HEATLH DEPT. – BEHAVIORAL HEALTH AUTHORITY / CORE SERVICE AGENCY
108 EAST MAIN STREET
SALISBURY, MD 21801
410-543-6981

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

NAME OF AGENCY/BUSINESS: ____________________________

ADDRESS: ____________________________

PHONE #: ____________________________

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 ONE YEAR FROM DATE OF SIGNATURE

☐ 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: ______________________________