

**Wicomico Local Behavioral Health Authority
Recovery- Transitional Housing 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 recovery-transitional housing 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 requested can not be more than \$500

2. Is individual presently a consumer of Public Behavioral Health Services (PBHS)? Yes ___
No ___

Substance Abuse Provider:

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? Please provide brief description of assistance needed:

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

a. 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)

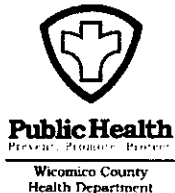
- A separate Consent/ Release of information for each agency/business/housing program will need to be completed so the LBHA can call to discuss the application**
- If you are not the substance abuse (SA) provider, have you included a Consent/Release of Information for the consumers SA provider?**
- All 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 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.) PROVIDE FINANCIAL ASSISTANCE WITH TRANSITIONAL HOUSING/RECOVERY _____

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

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: _____



Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

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