CHARLES COUNTY DEPARTMENT OF HEALTH
CORE SERVICE AGENCY

REQUEST FOR CLIENT SUPPORT – Laboratory Test

Date of Request: __________

1. Client's
Name:____
SSN:______________________ Phone Number: ______________________
DOB:___________ Address:______________________________________
____

2. Is the client in the Public Mental Health System? No___ Yes____
DSM-IV Diagnosis:____
Has client requested support from the Core Service Agency in the past? No___ Yes____
If yes, please provide date: _______________

3. Income (List sources and amounts): ______________________________________
____

4. Benefits Received (TCA, MA, SSI, etc.): ______________________________
____

5. Below, please list other sources contacted for support, date of contact and reason for denial. (This should include community, public, private, and family resources)

Source:___________________________ Date:____________ Reason:________________
___________________________ ____________ ________________
___________________________ ____________ ________________

10. Describe the laboratory tests to be purchased on behalf of the client.
____
____

11. I hereby certify that (All must be completed before requesting assistance from CSA)
___ The client does not have insurance coverage for the above test.
___ The tests are necessary to monitor psychiatric medications and are ordered by a provider in the Public Mental Health System.
___ The client has applied for Medical Assistance/Primary Adult Care (PAC)
- Date applied:___/___/___/
___ Attached copy of signed referral.

12. $______________ Total Cost of tests.
$______________ Amount to be paid by client. (If zero, requester certifies client cannot afford payment)
$______________ Amount to be paid by sources other than CSA
$______________ Amount of vendor discount, if any

$

Amount requested from Core Service Agency.

14. Attach an itemized quote or invoice from the vendor that verifies/explains the cost for the goods/services.

15. Date vendor must receive payment. (Allow seven days for CSA processing)

____

16. **Vendor Information:**
Name: ______________________________________
Address: ______________________________________
____
Telephone: ______________ Fax: ______________

17. Requesting Agency: ______________________________________
Contact Person: ______________________________________
Tele: ______________________________________
Fax: ______________________________________

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AMOUNT APPROVED ______________ **REQUEST DENIED**

Signature:______________________ **Date:**______________
CSA Staff

____
CSA Manager

____
MHA Director of Adult Services or
MHA Director of Child & Adolescent Services
(if over $250)

Directions for completing the form:

1. **The CSA funds can only be used to cover the cost of blood tests necessary to monitor psychiatric medications.**
2. **Lab tests must be ordered by providers in the Public Mental Health System.**
3. **All information requested above the dotted line must be completed by the Mental Health Provider, and include a signature by the provider completing the form and who can be contacted by the CSA regarding the application.**
4. **A copy of the referral must accompany the application.**
5. **A copy of the DHMH-Documentation for Uninsured Eligibility Benefit form must accompany the application.**
6. **Availability of funds is determined by the Mental Hygiene Administration. This assistance is only available for the duration that the funding is available.**