

**CHARLES COUNTY DEPARTMENT OF HEALTH
CORE SERVICE AGENCY**

REQUEST FOR CLIENT SUPPORT

Date of Request: _____

1. Client's Name: _____
SSN: _____ Phone Number: _____
DOB: _____ Address: _____

2. Is the client in the Public Mental Health System? No___ Yes___
What type of insurance does the client have? _____
DSM-V Diagnosis: _____
Has client requested support from the Core Service Agency in the past? No___ Yes___
If yes, please provide date: _____

3. Household Income (List sources and amounts): _____

4. Benefits Received (TCA, SSI, Food Stamps, etc.): _____

5. Number of children & adults living in the home: _____

6. Indicate any Housing Programs client has received or applied for (Continuum of Care,
Section 8, Rental Assistance) _____

7. Has client applied for/received assistance from MEAP? No ___ Yes ___
Date Applied: ___/___/___

8. If this is an educational expense, verify that this is part of their Service Plan and DORS
funding is not available: _____

9. At least three other resources (This should include community, public, private, and
family resources) must be contacted before applying to the Core Service Agency for
assistance. Please indicate what sources have been contacted and the outcome below:

Source: _____	Date: _____	Outcome: _____
_____	_____	_____
_____	_____	_____

10. Describe the goods or services the client needs assistance with. What caused them to be in this emergency situation?

11. Explain how the expenditure will assist the client in meeting his/her individual mental health treatment or rehabilitation goals.

12. Provide a specific plan indicating how the client intends on making payments in the future and prevent future need for emergency assistance.

13. \$ _____ Total Cost of Goods/Services
\$ _____ Amount to be paid by client. (If zero, requester certifies client cannot afford payment)
\$ _____ Amount to be paid by sources other than CSA

\$

Amount requested from Core Service Agency.

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

Please Note: All requests are processed at the CSA and then sent through the State of Maryland system. Payment will be received within 6 weeks. The CSA can make pledges on behalf of the client until payment is received. Please keep this time frame in mind when applying for assistance.

16. Vendor Information:

Name: _____

Address: _____

Telephone: _____

Fax: _____

17. Provider Agency Completing Form: _____

Contact Person: _____

Tele: _____

Fax: _____

\$

AMOUNT APPROVED

REQUEST DENIED

Signature: _____
CSA Staff

Date: _____

CSA Director or Assistant Manager

MHA Director of Adult Services or
MHA Director of Child & Adolescent Services
(if over \$1,000)

CSA Notes:

Directions for completing the form:

- 1. Eligible costs include:**
 - a. Security deposit, first month's rent,**
 - b. utility turn on or deposit,**
 - c. basic household goods to establish residence,**
 - d. past due utility, rent or mortgage when payment enables consumer to remain in the community placement and a plan for continuing payment by consumer is feasible,**
 - e. educational expenses only in concert with an approved Supported Employment or Individual Rehabilitation Plan when the item is not otherwise eligible for coverage by DORS or related program.**
- 2. The Core Service Agency is payer of last resort. This means all other resources must be explored and exhausted before the CSA will make a payment or pledge.**
- 3. Assistance is limited to \$1,000 per consumer per fiscal year.**
- 4. Assistance is limited to active consumers in the Public Mental Health System and receiving services from a PMHS provider.**
- 5. Assistance cannot be used to pay for dental care.**
- 6. Availability of funds is determined by the Behavioral Health Administration. This assistance is only available for the duration that the funding is available.**
- 7. 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.**
- 8. Items 10, 11 and 12 must be answered thoroughly. Please explain to the CSA why the assistance is needed, why the consumer is not able to manage the need independently or with other resources and how the consumer is going to ensure that this need does not arise in the future.**
- 9. Item 14: examples of itemized quotes or invoices include copy of bill or eviction notice, letter from landlord regarding past due rent, itemized quote for goods, etc.**