CHARLES COUNTY DEPARTMENT OF HEALTH
LOCAL BEHAVIORAL HEALTH AUTHORITY

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 Local Behavioral Health Authority 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 LBHA 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.

_____
_____
_____
_____
_____

11. What caused them to be in this emergency situation?

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

14. $_____ 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 LBHA

$

Amount requested from Local Behavioral Health Authority.

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

Please Note: All requests are processed at the LBHA and then sent through the State of Maryland system. Payment will be received within 6 weeks. The LBHA 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: _____

Signature: _____

By signing this form you are constituting a referral for assistance on behalf of your client and acknowledge our office may call you to obtain further information in order to process the request.

****

$

AMOUNT APPROVED _____ **REQUEST DENIED**

Signature:_____ **Date:_____**

LBHA Staff

_____

LBHA Director or Assistant Director

_____

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

LBHA 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 Local Behavioral Health Authority is payer of last resort. This means all other resources must be explored and exhausted before the LBHA 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 LBHA regarding the application.**
8. **Items 10-13 must be answered thoroughly. Please explain to the LBHA 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 15: 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.**