Mid Shore Behavioral Health, Inc.
Maryland Recovery Net
Client Support Services

Date:______________________

Consumer's County of Origin: _______________

PLEASE COMPLETE ALL SECTIONS OF THE FORM AND ENSURE IT IS LEGIBLE. INCOMPLETE FORMS WILL BE DENIED AND RETURNED. PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING FOLLOWING RECEIPT OF COMPLETED REQUEST.

Consumer Name:____ DOB: _____________________________

Address:____ County: ___________________________

Telephone #:____ Social Security #:___________________

Veteran: Yes No Gender: ____________________ Primary Language:___________________

Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown

Name and Contact information for client's State Care Coordinator (SCC):

____

Is the consumer actively engaged in a Fee-for-Service Public Behavioral Health System (PBHS) funded Substance Use Disorder-related treatment service? Yes No
Does the consumer have Medical Assistance? Yes No
If yes, MA number:_______________________________________
If no, date Medical Assistance Application was mailed (approximate if original date unknown): _________
Does the consumer have Medicare? Yes No

Has the consumer received this funding during this fiscal year (July 1-June 30)? Yes No

Please provide supporting documentation for request – lease, utility bill, eviction notice, etc.

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Please list <u>all</u> agencies, such as DSS and other charitable organizations, that have been contacted and note reason for refusal: <u>Must have contacted a minimum of three agencies.</u>

Agency Name:____

Contact Person:____

Telephone #:____

Result:____

Agency Name:____

Contact Person:____

Telephone #:____

Result:____

Agency Name:____

Contact Person:____

Telephone #:____

Result:____

All special need requests must show a sustainability plan. What is the plan to prevent a re-occurrence?

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How will the funds enable the individual to access or retain community based Behavioral Health Services? How will the funds support the individual's clinical treatment and/or recovery support plan goals?

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Please list all monthly income and expenses, documenting need for financial assistance: (add a page if needed). You must total the monthly income and expenses. If print, please ensure it is legible.

Monthly Income sources	**Amount (monthly)**	**Monthly Expenses**	**Amount (monthly)**
Salary/Wages		***Rent***	
SSI/SSDI		***Electric***	
TCA		***Gas/oil***	
Food Stamps		***Phone***	
Child support		***Auto related/Transportation***	
Other		***Food***	

		Court Judgments	
		Personal/Household	
		Water/Other Utilities	
		Other/Cable/etc…	
		Other	
		Other	
TOTAL:		**TOTAL:**	

***If other financial circumstances impact this person/family's budget please attach a detailed explanation and show totals.**

Total dollar amount requested:_______________________________________

Funding is needed by:____

Check should be made payable to:

Name:____

Address:____

Telephone #:____

Tax I.D. #:____

**Complete and attach a W-9 form and lease for all rental or security deposits.

Consumer Signature: ___________________________________

Telephone/Email: ______________________________
(Per COVID-19 requirements and restrictions consumer agreed via telehealth)
Please check box ☐

State Care Coordinator Signature:________________________

Telephone/Email: ______________________________

Mid Shore Behavioral Health, Inc.
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Consumer Name:________________________________

CSA USE ONLY

Approved Amount: __________ Denied**:** ____________ Withdrawn**:** _________ Date**:**_______________

Special Need Funds: ____________________________________

Comment: ____

Signature of staff processing request:

____

Executive Director, Behavioral Health Coordinator Manager or Board President Signature: ___________

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BHA Approval (if request is over $1,000.00): ____

CSA Special Needs Request Notes:

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Substance Use Disorder (SUD) Treatment Verification

1. Name of Consumer: ____

2. Is the consumer currently engaged in SUD-related treatment services?

   Yes No

3. Date of enrollment: ____

4. Name of treating SUD Clinician: ____

5. Signature of SUD Clinician: ____

   Date: ____

<u>Note to State Care Coordinators:</u>

Ineligible Use of Funds: Funds shall not be used for the purchase of or reimbursement of the following:

1. Goods and services for the use of employees, consultants, contractors, or staff of the LAA/LBHA or affiliated entity or for any friends or family members of employees, consultants, contractors, or staff of the LAA/LBHA or affiliated entity

2. Cell phones, cell phone services, and associated fees and charges.

3. Passports

4. Furniture, furnishings, and supplies for the operation of a recovery residence.

5. Communal supplies for the operation of recovery residence, including but not limited to toilet paper, cleaning, and household supplies.

6. Services that are directly or indirectly provided by MDRN approved providers.

7. Recovery residence operating expenses.

8. Recovery residence application fees, security deposits, move-in fees, or any other fees charges, or rent for a recovery residence.

9. Services or equipment that is reimbursable by the PBHS or other payer.

10. Co-pays for services reimbursable by the PBHS.

11. Clients' personal, family members', or friends' vehicle repairs, emissions tests, registration fees, transfer taxes, titling fees, insurance

12. Gasoline, including mileage reimbursement, for use in a client's personal, family members' or friends' vehicle.

13. Gym or health club memberships (unless prescribed by the treating physician).

14. Legal fees, fines, or debts.

15. Any other good or service not specified above for which BHA has not approved in writing.