Mid Shore Behavioral Health, Inc.
Maryland Recovery Net
Consumer Transportation Request Form

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

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

Please provide a detailed description of the transportation assistance needed and please state how the funds will provide the consumer access to PBHS SUD services.

_____

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Pick-up Location: _____ **Drop-off Location:** _____

_____ _____

_____ _____

_____ _____

Roundtrip? Yes No

How will transportation be provided when these funds no longer exist?

_____

_____

_____

_____

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:_____

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Contact Person:_____

Telephone #:_____

Result:_____

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Agency Name:_____

Contact Person:_____

Telephone #:_____

Result:_____
(If additional agencies contacted list the name, number contact person and result)

Total dollar amount requested:_____

Funding is needed by:_____

Check should be made payable to:

Name:_____

Address:_____

Telephone #:_____

Tax I.D. #:_____

Consumer Signature: _____

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

State Care Coordinator Signature:_____

Telephone/Email: _____

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Approved Amount: _____ Denied**:** _____ Withdrawn**:** _____ Date**:**_____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: _____

_____

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: _____