**Mid Shore Behavioral Health, Inc.**

**Mental Health Consumer Support Services**

**Pharmacy Assistance Request Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer: SS#: DOB: County:

Address: Consumer/Contact Person Telephone #:

Veteran: Yes No Gender: \_\_\_\_\_\_\_\_\_\_ Primary Language:

Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown

Please **print** the prescribed Medication(s) & Cost per Prescription **and attach copy of current prescription**.

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_$\_\_\_\_\_\_\_\_\_**

**Total Cost of Prescriptions**: $\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Participating Pharmacies (please circle)** Cantner’s Craig’s Craig’s Institutional

 Ridgely Edward’s Hill’s Stam’s Chestertown Pharmacy

Is client a consumer of Public Behavioral Health System? Yes No

Check all that apply: \_\_\_Mental Health \_\_\_Substance Use/Addictions

Does the client have private insurance? Yes No

Have available samples been accessed? Yes No

Have they applied for Med Bank? Yes No

Have they applied for Medical Assistance? Yes No

Provide a statement indicating all other resources, including Medicaid (**include a copy of the Medicaid application with this initial request**) and the Indigent Drug program, which have been explored or accessed: How will payment occur when assistance ends?

**IF this is a subsequent application, the consumer must call Medicaid (855-642-8572) to determine the status of their application and must provide the tracking #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Once approved the medication must be obtained from the pharmacy within 48 hours.**

**There is a $2.00 co-pay per medication.**

Requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CSA USE ONLY**

**Medicaid ID Number:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer Co-pay: $

Amount of MSBH Approval: $

Total Amount of Prescriptions: $

Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Posted \_\_\_\_\_\_\_\_\_ Consumer File \_\_\_\_\_\_\_\_\_ Paid Pharmacy\_\_\_\_\_\_\_\_\_**

 Date Date Date