Mid Shore Behavioral Health, Inc.
Child and Adolescent Consumer Support Services
Consumer Special Need Request Form

Youth being referred must have Medicaid and be actively engaged in a Fee-For-Service Public Behavioral Health System outpatient mental health treatment.

Date: _____

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.

Child/Adolescent Name:_____ DOB: _____

Guardian Name: _____ DOB:_____

Address:_____ County: _____

Telephone #:_____Child/Adolescent Social Security #:_____

Gender: _____Primary Language:_____

Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown

Provider/Staff Making Request & Phone & Email:

_____

Is client a consumer of Public Behavioral Health System? ☐ Yes ☐ No
Check all that apply: ☐ Mental Health ☐ Substance Use/Addictions
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 private insurance? ☐ Yes ☐ No

Please provide a detailed description of the special need being requested and reason for request. Please include a summary of the consumer's circumstances pertaining to behavioral health and community stability as well as what led to this need. 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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_____

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Please list all household monthly income and expenses, documenting need for financial assistance: (add a page if needed). The full food stamps amount must be included in expenses. You must total the monthly income and expenses. Income must exceed expenses. Please be 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.**

Guardian Signature: _____

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

Behavioral Health Provider Signature: _____

Email completed form and supporting documentation to childandadolescentconsumersupport@midshorebehavioralhealth.org or Fax to the attention of Sarah Fegan at 410-770-4809.

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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