**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.**

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

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?**

**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:**

 \_\_\_\_\_\_\_