

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

Adults being referred to this program must be enrolled in Medicaid, have no private insurance, be actively engaged in a Fee-For-Service Public Behavioral Health System (PBHS) outpatient mental health treatment, and have an income.

Date submitted: _____

PLEASE COMPLETE ALL SECTIONS OF THE FORM AND ENSURE IT IS LEGIBLE. INCOMPLETE SECTIONS WILL DELAY APPLICATION REVIEW.

Consumer Name: _____ DOB: _____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Telephone: () - _____

Email: _____ @ _____ Veteran: Y N

Gender: _____ Primary Language: _____ Ethnicity: _____

Provider/Staff submitting request on behalf of the Consumer:

Name: _____ Email: _____ @ _____

Is the client a consumer of the Public Behavioral Health System (PBHS/Medicaid, etc.)? Yes ___ No ___

Check all that apply: Mental Health ___ Substance Use ___

Does the consumer have Medical Assistance (MA)? Yes ___ No ___

If YES, list MA number: _____

If NO, what date was the MA application submitted (approximate if original date unknown): _____

Does the consumer have Medicare? Yes ___ No ___ Private insurance? Yes ___ No ___

Please provide a detailed description of the special need, as well as what led to the request. Include a summary of the consumer's circumstances as it pertains to behavioral health and community stability. *Supporting documentation is required - lease, utility bill, eviction notice, order list, etc.

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Please list all **monthly** income and expenses, documenting need for financial assistance, and **total**.

<u>ALL</u> sources of INCOME	Amount of income \$\$	Monthly EXPENSES	Amount of expenses \$\$
<i>Salary/Wages</i>		<i>Rent/Mortgage</i>	
<i>SSI/SSDI</i>		<i>Electric</i>	
<i>TCA (temporary cash assistance)</i>		<i>Gas/Oil</i>	
<i>Food Stamps</i>		<i>Phone</i>	
<i>Child support</i>		<i>Auto related/ Transportation</i>	
<i>Other</i>		<i>Food (enter food stamp amount from income column)</i>	
		<i>Court Judgment(s)</i>	
		<i>Personal/ Household</i>	
		<i>Water</i>	
		<i>Other</i>	
TOTAL	\$.	TOTAL	\$.

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Total dollar amount requested: _____ Funding is needed by: _____

**Check should be made payable to:
*No funds will be issued directly to the consumer***

Business Name: _____

Street Address: _____

Account # (if applicable): _____ Telephone: (____) _____ - _____

If application is approved additional forms may be required (ex. housing – W-9 form from landlord)

Consumer Name: _____

(Per COVID-19 requirements and restrictions, consumer agreed via telehealth) Please check box

Behavioral Health Provider Signature: _____

As 'gatekeeper' of the submission process, the BH provider must review for completion and accuracy BEFORE signing

**RETURN COMPLETED APPLICATION TO:
ConsumerSupport@midshorebehavioralhealth.org
Or fax: 410-770-4809**

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CSA USE ONLY

Consumer Name: _____

Approved Amount: _____ **Approved Date:** _____

Special Need Request:

- Pharmacy
- Transportation
- Language Interpretive Services
- Vital Records
- Transitional Support Needs: Housing (Utility)
- Transitional Support Needs: Clothing/Personal Hygiene
- Transitional Support Needs: Education/Employment
- Transitional Support Needs: Medical

Program Monitor/Staff: _____

Programs Director: _____

Chief Executive Officer: _____

BHA (if applicable): _____

CSA Notes: _____



Homelessness Solutions Program (HSP)

Program Services

- Emergency Shelter
- Housing Stabilization – Rapid Rehousing and Homelessness Prevention
 - Eligibility for Rapid Rehousing:
 - Must be “literally homeless” (i.e. living in emergency shelter or another place that is not meant for human habitation)
 - Eligibility for Homelessness Prevention:
 - Must be “at-risk” of homelessness
 - Have an income limit below 30% Area Median Income (AMI) **OR**; below 50% AMI per COVID-19 emergency funds
 - Must be able to demonstrate there are not sufficient resources or support networks to prevent moving into emergency shelter
- Outreach
- *New* Homeless Youth Program

Community Providers

- **Caroline County**
 - ◆ **His Hope Ministries, (443) 448-7297** – Emergency Shelter, Housing Stabilization, Outreach and New Homeless Youth Program
 - ◆ **Martin's House and Barn, (410) 634 -2537** – Emergency Shelter, Housing Stabilization, and Outreach
- **Dorchester County**
 - ◆ **Delmarva Community Services, (410) 901-2996** – Emergency Shelter, Housing Stabilization and Outreach
- **Kent County**
 - ◆ **Maryland Rural Development Center, (410) 482-4810** - Emergency Shelter, Housing Stabilization and Outreach
- **Queen Anne's County**
 - ◆ **Haven Ministries, (410) 758-0129** – Outreach
 - ◆ **Queen Anne's County Department of Housing and Community Development, (410) 758-3977** – Emergency Shelter, Housing Stabilization and Outreach
- **Talbot County**
 - ◆ **Neighborhood Service Center, (410) 822-5015** – Emergency Shelter, Housing Stabilization and Outreach

* ALL HSP Providers serve in all five mid-shore counties.