Calvert County Health Department
Local Behavioral Health Authority

Client Support Services Request for Funds

Must attach the following with this application in order to be processed:

- ☐ Copy of treatment plan
- ☐ Receipt of payment or Invoice
- ☐ Signed release of information
- ☐ Budget spreadsheet

Date of Request: _____

Consumer's Name: _____ _____ _____
First MI Last

DOB: _____ Age: _____ Social Security Number: _____

Current Address: _____

DSM-V Diagnosis: _____ Total Amount you are requesting for support: _____

Do you have Medicaid? Yes____ No____

What treatment services are you currently engaged in?

- ❑ Inpatient Mental Health Treatment
- ❑ Residential Substance Use Disorder Treatment
- ❑ Mental Health Group Therapy
- ❑ Substance Use Disorder Group Therapy
- ❑ Mental Health Individual Therapy
- ❑ Substance Use Disorder Individual Therapy
- ❑ Other _____

What is the name of your provider & credentials? _____ _____
Name Credentials

Please describe the goods and/or services to be purchased on behalf of the consumer:

_____

_____

_____

Requesting these funds should be a last resort. List three other resources that you have already contacted and the date, who you talked to, and explain the outcome:

1. Source: _____Name: _____ Date: _____

   Outcome: _____

2. Source: _____Name: _____ Date: _____

   Outcome: _____

Updated 7/5/2022

3. Source: ________________________ Name: ________________________ Date: _________

Outcome: ____

Please explain how this request will assist the consumer in meeting their individualized treatment/recovery goals:

____

____

____

By signing this form, you certify that all of the information provided is true and correct to the best of your knowledge.

____________________	____________________	____________________
Agency	Print Staff's Name & Credentials	Staff's Signature

____________________	____________________	____________
Consumer's Signature	Staff's Phone Number	Date

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For internal use only

Has the requester attached a letter signed by the consumer's treatment provider, indicating the need for the service being requested? Yes _____ No _____

Has the requester attached the bill or an invoice from the vendor that verifies the cost of the service? Yes _____ No _____

______________________________	____________________
LBHA's Staff Signature for Approval	Date Approved

______________________________	____________________
LBHA's Director Signature for Approval	Date Approved

For items above the amount requested threshold:

______________________________	____________________
BHA Signature	Date Approved
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Ineligible Use of Funds: Funds shall not be used for the purchase of or reimbursement for:

- Goods and services for the use of employees, consultants, contractors, or staff of the LBHA, CSA or affiliated entity or for any friends or family members of employees, consultants, contractors, or staff of the LBHA, CSA or affiliated entity.
- Cell phones, cell phone services, and associated fees and charges.
- Passports
- Furniture, furnishings, and supplies for the operation of a PBHS provider owned or operated residence or program.
- Communal supplies for the operation of recovery residence, including but not limited to toilet paper, cleaning and household supplies, bedding, towels, cutlery, cooking utensils, and appliances.
- Services that are directly or indirectly provided by or are the responsibility of PBHS providers.
- Operating expenses for a PBHS provider owned or operated residence, recovery residence, or program
- Application fees, security deposits, move-in fees, or any other fees charges, or rent for a PBHS provider owned or operated residence, recovery residence, or program
- Services or equipment that is reimbursable by the PBHS or another payer.
- Co-pays for services reimbursable by the PBHS.
- Clients' personal, family members', or friends' vehicle repairs, emissions tests, registration fees, transfer taxes, titling fees, insurance premiums, monthly payments or down payments.
- Gasoline, including mileage reimbursement, for use in a client's personal, family members' or friends' vehicle.
- Transportation to or in support of a PBHS funded non-treatment services, including, but not limited to PRP.
- Gym or health club memberships (unless prescribed by the treating physician).
- Legal fees, fines, or debts.
- Funeral costs.
- Dental costs.
- Cash payments directly to clients, family members of clients, or friends or clients.
- Any other good or service not specified above for which BHA has not approved in writing.

Extra if Necessary:

Requesting these funds should be a last resort. List three other resources that you have already contacted and the date, who you talked to, and explain the outcome:

4. Source: _____Name: _____ Date: _____

   Outcome: _____

5. Source: _____Name: _____ Date: _____

   Outcome: _____

6. Source: _____Name: _____ Date: _____

   Outcome: _____

7. Source: _____Name: _____ Date: _____

   Outcome: _____

8. Source: _____Name: _____ Date: _____

   Outcome: _____

9. Source: _____Name: _____ Date: _____

   Outcome: _____

10. Source: _____Name: _____ Date: _____

    Outcome: _____

11. Source: _____Name: _____ Date: _____

    Outcome: _____

12. Source: _____Name: _____ Date: _____

    Outcome: _____

13. Source: _____Name: _____ Date: _____

    Outcome: _____

14. Source: _____Name: _____ Date: _____

    Outcome: _____

15. Source: _____Name: _____ Date: _____

    Outcome: _____