# CALVERT COUNTY HEALTH DEPARTMENT
# LOCAL BEHAVIORAL HEALTH AUTHORITY

P.O. Box 980
Prince Frederick, Maryland 20678

Dr. Nimfa Teneza-Mora, MD MPH
Health Officer

Andrea McDonald-Fingland, LCSW-C
Director, Calvert County Local
Behavioral Health Authority

STATE OF MARYLAND

Phone (443) 295-8584

Fax (443) 968-8979

www.calverthealth.org


## Client Support Services Request for Funds - Adults

**Date of Request:** _____ **Total Amount you are requesting for support:** _____

**Consumer's Name (First, MI, Last):** _____

**DOB:** _____ **Age:** _____ **Social Security Number:** _____

**Current Address:** _____

**Sex:** _____ **Race:** _____ **Ethnicity:** _____

**Special Populations (Please check all that apply):**

- ☐ Deaf and Hard of Hearing
- ☐ Unhoused
- ☐ Transitional Housing
- ☐ Limited English Proficient
- ☐ Declined to answer/Unknown

**DSM-V Diagnosis:** _____ **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?** _____

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

_____
_____
_____

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

_____
_____
_____

Updated 1/21/2026

**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. There is space provided for up to 2 separate items requested:**

1. Source: _____Name: _____ Date: _____
   Outcome: _____
2. Source: _____Name: _____ Date: _____
   Outcome: _____
3. Source: _____Name: _____ Date: _____
   Outcome: _____
4. Source: _____Name: _____ Date: _____
   Outcome: _____
5. Source: _____Name: _____ Date: _____
   Outcome: _____
6. Source: _____Name: _____ Date: _____
   Outcome: _____

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

_____
Staff's Agency, Printed Name, & Signature

_____ _____
Consumer Signature Date

| Name of Household member | |
|---|---|
| **Income type with amount (monthly)** | |
| SSDI (disability) | |
| SSI (supplemental) | |
| Temporary Cash Assistance (TCA) | |
| Temporary Disability Assistance (TDAP) | |
| Child Support | |
| Food Stamps | |
| Alimony | |
| Employment | |
| Unemployment | |
| Other: _____ | |
| **TOTAL** | |
| **Monthly Expenses** | |
| Rent/Mortgage | |
| Utilities | |
| Phone | |
| Car (payment + insurance) | |
| Groceries | |
| Gas | |
| Child care (if applicable) | |
| Loans (credit cards, student loans, etc) | |
| Other: _____ | |
| **TOTAL** | |
| **TOTAL INCOME:** | |
| **TOTAL EXPENSES:** | |
| **TOTAL HOUSEHOLD INCOME:** | |
| **TOTAL HOUSEHOLD EXPENSES:** | |

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## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

| CLIENT INFORMATION | | | |
|---|---|---|---|
| Last Name | First Name | MI | Social Security No. |
| Street Address | | | Apt. # / P.O. Box |
| City | State | Zip Code | Date of Birth |
| Home # | Work # | Cell # | |

**RELEASE OF INFORMATION**

- I, the client, have read the statements within this document and authorize the following organization to disclose such information as described within this document.
- I understand that if I am a criminal justice referral, I may not revoke consent until I have been released from confinement and/or completed parole or probation.
- I understand that if I am not a referral from the criminal justice system, I may revoke this authorization at any time by giving written notice of my revocation to Calvert County Local Behavioral Health (LBHA). I understand that revocation of this authorization will not affect any action that LBHA or others named or unnamed took in reliance on this authorization before LBHA received my written notice of revocation.
- I acknowledge that the material authorized for release may contain alcohol, chemical dependency, psychiatric, HIV testing or results, or AIDS information or other personal information.
- I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws.
- If these records contain information from another provider this information will not be disclosed unless the other provider has not prohibited this, it is permitted by law, and if you check the following box granting permission of release of information: ☐
- I understand that, once information is released, this facility cannot prevent the recipient from further disclosing the information.

Organization: _____ Information released to: Local Behavioral Health Authority

**I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR, Part 2, and Conditions of Participation for Community Mental Health Centers, 42 CFR, Part 485, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.**

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[redacted]

This authorization will expire one year from the date signed, unless a specific expiration date, event, or condition is named here: _____. For verbal communication, this authorization will expire upon discharge from the program. The authorization covers only the dates specified below unless I check for ALL records to be released. I understand that I have the right to refuse to sign this Authorization for Release of Protected Health Information. I understand that authorizing the disclosure of this information is voluntary, and that I need not sign this form to assure treatment.

## AUTHORIZED DISCLOSURE

I hereby authorize: Calvert County Local Behavioral Health Authority,

Address: P.O. Box 980 Prince Frederick, MD 20678

Phone Number: (443) 771-0893

to disclose information to, and obtain information from, the following organization(s):

- Organization: _____

  Address: _____

  Phone Number: _____

  for the *following dates (Today's date)*: _____ -to- _____

SELECT PORTIONS OF THE RECORD TO BE RELEASED:

X Information regarding service provided including demographics, finances, diagnosis, etc.
X Treatment Plan

## SIGNATURES

Signature of Client: _____ Date: _____

Signature of *Authorized Representative*: _____ Date: _____

Signature of Behavioral Health Staff: _____ Date: _____