

**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](http://www.calverthealth.org)**

**Client Support Services Request for Funds - Children & Adolescents**

**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):**

<input type="checkbox"/> Deaf and Hard of Hearing	<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Declined to answer/Unknown
<input type="checkbox"/> Unhoused	<input type="checkbox"/> Limited English Proficient	

**DSM-V Diagnosis: \_\_\_\_\_ Do you have Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_**

**What treatment services are you currently engaged in?**

<input type="checkbox"/> Inpatient Mental Health Treatment	<input type="checkbox"/> Mental Health Individual Therapy
<input type="checkbox"/> Residential Substance Use Disorder Treatment	<input type="checkbox"/> Substance Use Disorder Individual Therapy
<input type="checkbox"/> Mental Health Group Therapy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Substance Use Disorder Group Therapy	

**What is the name of your provider & credentials? \_\_\_\_\_**

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

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

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**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.**

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Staff's Agency, Printed Name, & Signature

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Consumer/Guardian Signature

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Date

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

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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

<b>CLIENT INFORMATION</b>			
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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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:**

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

**SIGNATURES**

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of *Authorized Representative*: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Behavioral Health Staff: \_\_\_\_\_ Date: \_\_\_\_\_