Calvert County Health Department
Local Behavioral Health Authority

Client Support Services Request for Funds- Adults

Must attach the following with this application to be processed:

- ☐ Copy of treatment plan
- ☐ Receipt of payment or Invoice
- ☐ Signed release of information
- ☐ Budget spreadsheet
- ☐ Letter from the treating physician

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: _____

Updated 6/6/2024

2. Source: ____________________ Name: ____________________ Date: __________

   Outcome: ____

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 the treatment plan, indicating the need for the service being requested?

Yes ☐ No ☐

Has the requester attached the Release of Information as well as a letter from the treating physician to confirm active engagement in services?

Yes ☐ No ☐

Has the requester attached the budget spreadsheet to indicate the need for this request?

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 of $1,000:

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

(1) 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.
(2) Cell phones, cell phone services, and associated fees and charges.
(3) Passports
(4) Furniture, furnishings, and supplies for the operation of a PBHS provider owned or operated residence or program.
(5) Communal supplies for the operation of a PBHS provider owned or operated residence or program, including but not limited to toilet paper, cleaning and household supplies, bedding, towels, cutlery, cooking utensils, and appliances.
(6) Services that are directly or indirectly provided by or are the responsibility of PBHS providers.
(7) Operating expenses for a PBHS provider owned or operated residence or program.
(8) 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.
(9) Services or equipment that is reimbursable by the PBHS or another payer.
(10) Co-pays for services reimbursable by the PBHS.
(11) Client's personal, client's family members', or client's friend's vehicle repairs, emissions tests, registration fees, transfer taxes, titling fees, insurance premiums, monthly payments or down payments.
(12) Gasoline, including mileage reimbursement, for use in a client's personal, family members' or friends' vehicle.
(13) Transportation to or in support of a PBHS funded non-treatment services, including, but not limited to a Psychiatric Rehabilitation Program (PRP).
(14) Gym or health club memberships (unless prescribed by the treating physician).
(15) Legal fees, fines, or debts, except as otherwise specified in the Transitional Support Needs section of this document.
(16) Cash payments or cash equivalent payments (e.g., gift cards) directly to clients, family members of clients, or friends of clients.
(17) Dental care costs, effective January 8, 2009.
(18) Food
(19) Good or services for individuals who are not actively engaged in a Fee-for- Service (FFS) Public Behavioral Health System (PBHS) funded outpatient mental health service, inclusive of Mobile Treatment Services (MTS) or
Assertive Community Treatment (ACT), psychiatric rehabilitation program (PRP), residential rehabilitation program (RRP), residential crisis, respite, mental health case management or supported employment services.
(20) Goods or services for children and adolescent Public Behavioral Health System (PBHS) service recipients or for children and adolescents whose parent, legal guardian, family member, or caretaker is a PBHS service recipient.
(21) Goods or services that are intended for purely diversional or recreational purposes.
(22) 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: _____