**WORCESTER COUNTY CORE SERVICE AGENCY**
**FY 2017 REQUEST FOR FINANCIAL ASSISTANCE TO PAY FOR RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES**

## Instructions:

1. This form is to be used to request payment by the Worcester County Core Service Agency for rent/utilities and other personal items/services. CSA funds are available for one time use only.

2. The referral party is the person making the request on behalf of the client and usually is the client's therapist, case manager, advocate or social worker. Applicant must verify the following:
   - **a.** Individual is involved in the Public Behavioral Health System (PBMS);
   - **b.** Funds are being used to alleviate a problem;
   - **c.** Individual has no personal financial resources to cover incurred expenses
   - **d.** All other resources have been exhausted; **and**
   - **e.** No charitable, or religious organizations, or individuals can assist.

3. Complete Section I, along with the attached release of information. Without a completed release, the application **cannot** be processed. Please ensure that a release is completed for any person, agency or organization that is involved with the assistance application, should the WCCSA need to contact them for additional information.

4. Fax the completed form and release(s) to the WCCSA for authorization at **410-632-0065**.

5. The WCCSA Director or designee will complete Section II and notify applicant of authorization or denial.

6. The use of Client Support funds is governed by the requirements and conditions set by the Behavioral Health Administration. BHA may require written approval for amounts exceeding certain limits.

7. The WCCSA may require a co-payment or use of funds from other agencies in addition to WCCSA funding.

# WORCESTER COUNTY CORE SERVICE AGENCY
## FY 2017 REQUEST FOR FINANCIAL ASSISTANCE FOR RENT/UTILITIES AND OTHER PERSONAL ITEMS/SERVICES

**SECTION I. To be completed by referring party**

*Date of Request:*_____

Client Name: _____ [ ] adult [ ] child/adol

Social Security Number: _____ DOB: _____

Address: _____

Phone Number: _____

Provider/Program Name: _____

Contact Person: _____

**Eligibility Criteria**

1. Is the client in the Public Behavioral Health System? Yes_____ No_____
   ICD-10 Diagnosis: _____
2. Has the client received support from the CSA in the past? Yes_____ No_____
   If yes, please provide date: _____
3. Number of children living in the home: _____
4. Number of roommates: _____ Is this request made on behalf of all roommates? _____
5. Indicate any Housing Programs client has received or applied for (Shelter Plus Care, Section 8, Rental Assistance, RRP): _____
6. Please list at least **3** other sources that have been contacted for support and reason for denial:

   _____

   _____

   _____
7. If this is an educational expense, verify that this is part of their Service Plan and DORS funding is not available: _____
8. Describe the goods or services to be purchased on behalf of the client and the reason for the need.

   _____
9. Explain how the expenditure will assist the client in meeting his/her individual behavioral health treatment or rehabilitation goals. _____

   _____
10. Provide a specific plan indicating how the client intends on making payments in the future and prevent future need for emergency assistance. _____

    _____

11. Please provide *all* monthly income and expenses:

| **Monthly Household Income:** | **Monthly Household Expenses:** |
|---|---|
| Wages: $_____ | Rent: $_____ |
| SSI/SSDI: $_____ | Electric/Gas: $_____ |
| Child Support: $_____ | Phone: $_____ |
| Other*: $_____ | Transportation: $_____ |
| **Total:** $_____ | Cable: $_____ |
| | Food*: $_____ |
| | Other: $_____ |
| | **Total:** $_____ |

*Do not include food stamp allotment as income or food paid for by food stamps as an expense

12. Attach an itemized quote or invoice from the vendor that verifies/explains the cost for the goods/services.

$_____ Total cost of goods/Services

$_____ Amount to be paid by client (If zero, requester certifies client cannot afford payment)

$_____ Amount to be paid by sources other than CSA

$_____ Amount of vendor discount, if any

$_____ **Amount Requested from Core Service Agency**

13. **Vendor Information:**

Name: _____

Address: _____

Telephone:_____ Date vendor must receive payment: _____

If approved, make check payable to _____ Fed ID#_____

***SECTION II: To be completed by the WCCSA Director/Designee***

*APPROVED:* _____ *Amount:*_____ *Payable to* _____

*DENIED:* _____ *COMMENTS:* _____

_____

*Signature of WCCSA Director/Designee:*_____ *Date:*_____

BHA Authorization (if over $1000)

*Signature of BHA Director of Adult Services or Child/Adolescent Services:* _____ *Date:* _____

***WORCESTER COUNTY CORE SERVICE AGENCY***
An Agency of the Worcester County Health Department
***P.O. BOX 249 ▪ SNOW HILL, MARYLAND 21863-0249***
***410-632-3366 ▪ FAX: 410-632-0065***

**CONSENT TO *release/obtain* CONFIDENTIAL INFORMATION**

In order to ensure continuity of care, I, _____

authorize Worcester County Core Service Agency to obtain information from _____

_____

and release information to _____

for the purpose of payment arrangements for: _____.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be obtained without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) And that in any event this consent expires:

__**X**__ After one year from the date of execution.
_____ When the patient ceases to receive services from either agency.
_____ Other (Please specify)_____

Executed this _____ day of _____, 20____

DOB: _____ _____
**Signature of Consumer, Parent, or Guardian**

SSN: _____ _____
**Signature of Witness**

PLEASE DIRECT ALL CORRESPONDENCE TO:

**Worcester County Health Department**
**Core Service Agency**
**PO BOX 249**
**SNOW HILL, MD 21863**

ATTENTION: _CORE SERVICE AGENCY___ SITE: _SNOW HILL_____