Mid Shore Behavioral Health, Inc.
Consumer Support Services
Consumer Special Need Request Form

Date: ________________

PLEASE COMPLETE ALL SECTIONS OF THE FORM AND ENSURE IT IS LEGIBLE. INCOMPLETE FORMS WILL BE DENIED AND RETURNED. PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING FOLLOWING RECEIPT OF COMPLETED REQUEST.

Consumer Name:_______________________________________ DOB: ____________________________

Address:____ County: __________________________

Telephone #:____ Social Security #:___________________

Veteran: Yes No Gender: ___________________ Primary Language:___________________

Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown

Provider/Staff Making Request & Phone & Email:

____

Is client a consumer of Public Behavioral Health System? Yes No
Check all that apply: ___Mental Health ___Substance Use/Addictions
Does the consumer have Medical Assistance? Yes No
If yes, MA number:_____________________________________
If no, date Medical Assistance Application was mailed (approximate if original date unknown): _________
Does the consumer have Medicare? Yes No
Does the consumer have private insurance? Yes No

Please provide a detailed description of the special need being requested and reason for request. Please include a summary of the consumer's circumstances pertaining to behavioral health and community stability as well as what led to this need. Please provide supporting documentation for request – lease, utility bill, eviction notice, etc.

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Please list all agencies, such as DSS and other charitable organizations, that have been contacted and note reason for refusal: Must have contacted a minimum of three agencies.

Agency Name:____

Contact Person:____

Telephone #:____

Result:____

Agency Name:____

Contact Person:____

Telephone #:____

Result:____

Agency Name:____

Contact Person:____

Telephone #:____

Result:____

All special need requests must show a sustainability plan. What is the plan to prevent a re-occurrence?

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Please list all monthly income and expenses, documenting need for financial assistance: (add a page if needed). You must total the monthly income and expenses. Please be legible.

Monthly Income sources	Amount (monthly)	Monthly Expenses	Amount (monthly)
Salary/Wages		*Rent*	
SSI/SSDI		*Electric*	
TCA		*Gas/oil*	
Food Stamps		*Phone*	
Child support		*Auto related/Transportation*	
Other		*Food*	
		Court Judgments	
		Personal/Household	
		Water/Other Utilities	
		Other/Cable/etc…	
		Other	
		Other	
TOTAL:		**TOTAL:**	

***If other financial circumstances impact this person/family's budget please attach a detailed explanation and show totals.**

Total dollar amount requested:_______________________________________

Funding is needed by:____

Check should be made payable to:

Name:____

Address:____

Telephone #:____

Tax I.D. #:____

**<u>Complete and attach a W-9 form and lease for all rental or security deposits.</u>

Consumer Signature: ___________________________________

Telephone/Email: _______________________________
(Per COVID-19 requirements and restrictions consumer agreed via telehealth)
Please check box ☐

Behavioral Health Provider Signature: ___________________________________

CSA USE ONLY

Approved Amount: ___________ Denied: ______________ Withdrawn: __________ Date:________________

Special Need Funds: ____

Comment: ____

Signature of staff processing request:

____

Executive Director, Deputy Director, or Board President Signature: _________________________________

BHA Approval (if request is over $1,000.00): ____

CSA Special Needs Request Notes:

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