

**Mid-Shore Mental Health Systems, Inc.  
Consumer Support  
Client Special Need Form FY10**

DATE \_\_\_\_\_

**(Please Print)**

Client Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Last, First, Middle Initial

Address: \_\_\_\_\_ County: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Is client a consumer of Public Mental Health Services?      Yes                      No

Is consumer presently receiving mental health services?      Yes                      No

Does the consumer have Medical Assistance?      Yes                      No

If yes, MA number: \_\_\_\_\_

If no, date PAC Application was mailed (approximate if original date unknown): \_\_\_\_\_

Does the consumer have Medicare?                      Yes                      No

**What assistance is being requested? Why is it needed now (explain circumstance)? Provide description of assistance needed. ( write legibly)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list **all** agencies such as DSS and other charitable organizations that have been contacted and note reason for refusal: (Must have name of contact person)

Agency Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Result: \_\_\_\_\_ Result: \_\_\_\_\_

If additional agencies contacted list the name, number contact person and result.

**Consumer Name** \_\_\_\_\_

How will the consumer sustain a budget after this payment? What is the plan to prevent a re-occurrence?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note income and monthly 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 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         |                  |
|                        |        | 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. #: \_\_\_\_\_

**Complete and attach a W-9 form for all rental or security deposits. (Our auditors require this and we cannot process this request without it.)**

**Requestor Signature:** \_\_\_\_\_ **Supervisor Signature:** \_\_\_\_\_

Telephone/E mail \_\_\_\_\_ Telephone/E mail \_\_\_\_\_

**Please be available so we can process this request timely. If reaching you by e-mail is quicker please include or e-mail.**

**Consumer Name** \_\_\_\_\_

**CSA USE ONLY**

Approved Amount \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

Special Needs Funds \_\_\_\_\_ PATH Funds \_\_\_\_\_

Comment: \_\_\_\_\_

Signature: \_\_\_\_\_

Executive or Clinical Director's Signature: \_\_\_\_\_

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