Mid-Shore Mental Health Systems, Inc.
Consumer Support Services
Consumer Special Need Request Form FY12

DATE:__________________

Please complete all sections. Incomplete forms will be denied and returned to requestor. Please print legibly

Consumer Name:____ DOB: ______________________________

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

Please provide a detailed description of the special need being requested and reason for request. Please include a summary of the consumer's circumstances that led to the need.

(Please provide supporting documentation for request – lease, utility bill, evictions, etc.)

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Please list <u>all</u> agencies such as DSS and other charitable organizations that have been contacted and note reason for refusal: (Must have contacted a minimum of 3 agencies)

Agency Name: _______________	Agency Name:_______________	Agency Name: ______________________
Contact Person:_______________	Contact Person:_______________	Contact Person:______________________
Telephone #: _______________	Telephone #: _______________	Telephone #: ______________________
Result:_____________________	Result:_____________________	Result:____________________________

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

CSA USE ONLY: Posted: _____________ Paid: ________________ Consumer File: ____________

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

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Please note 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	
		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**

Requestor Signature:__________________________ **Supervisor Signature**:________________________________

Telephone/E mail ______________________________ Telephone/E mail ____________________________________

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CSA USE ONLY

Approved Amount: ____________ **Disapproved:** ________ **Withdrawn:** __________ **Date:**________________

Special Need Funds: __________________ **PATH Funds:** _______________

Comment: ____

Signature: ____

Executive or Clinical Director's Signature: ____

MHA Approval (if request is over $500.00): ____

CSA Special Needs Request Notes: