Behavioral Health System Baltimore

Instructions: Application for Financial Assistance to Purchase Medication

Eligibility:

- Inability to pay for psychotropic medications due to all of the following:
  - Lack of funds,
  - Insufficient insurance coverage, and
  - Inability to obtain samples.
- Individuals are expected to apply for insurance coverage before applying for these funds. **Proof of application is required.**
- Individuals may only access funds one time per year.

Application Process:

1. A provider working with the individual to apply for financial assistance will:
   a. Call the approved pharmacy listed below to get prices for each psychiatric medication for which payment is being requested.
   b. Complete both pages of the application. Incomplete applications will be returned.
   c. Email the completed application to BHS Baltimore at clinical.services@bhsbaltimore.org
2. A Rehabilitation and Treatment Coordinator will review your application within one business day and will email an approval or denial back to the originating email address. Please note if the approval/denial should be emailed to a different address.
3. The approved application will be emailed to the pharmacy by the Rehabilitation and Treatment Coordinator ahead of time and a copy of the approved form will be emailed back to the provider. The pharmacy will then bill BHS Baltimore.

Approved Pharmacy Contact Information

The following pharmacy is the only pharmacy authorized to bill BHS Baltimore for medication:

Mount Vernon Pharmacy
100 W. Read (at the corner of Read and Cathedral St.)
(P) 410-539-8030 (F) 410-539-8115

If you have any questions about how to complete this application send an email to clinical.services@bhsbaltimore.org **. An email is the primary method of communication, while BHSB continues to work remotely. There is no longer a fax option to submit this application.**

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Application for Financial Assistance to Purchase Medication

Please complete all information in Section I and email the two-page form to BHS Baltimore at clinical.services@bhsbaltimore.org . Incomplete applications will be returned. For more detailed instructions, see the separate instructions page.

Section I: To be completed by provider and forwarded to BHS Baltimore Services Manager

Client Name: _____ DOB: _____ SSN: _____

Address: _____

Telephone Number: _____ Date of Request: _____

Name of Responsible Person: _____

Provider/Program Name: _____

Contact Person: _____

Pharmacy Name: _____

Each of the following criteria must be met to be eligible for financial assistance. Please check all that apply and list the person's name who verified the information and the date of verification.

A. ☐ Individual has no insurance coverage.
Person making verification: _____ Date: _____

B. ☐ Individual has applied for health insurance; and
Person making verification: _____ Date: _____
(Attach first page of application, printout of confirmation of online application, or statement from client indicating the date he/she applied if pending, or written explanation of why applicant does not qualify.)

C. ☐ Physician cannot provide samples and/or prescription(s) are not covered by pharmaceutical manufacturer's patient assistance program.
Person making verification: _____ Date: _____

☐ Pharmacy Invoice Form is attached

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For BHSB internal use only:

Section II: To be completed by BHS Baltimore.

☐ Individual has not received this funding in the past year.

☐ Approved: Amount: $ _____ ☐ Denied

Comments:

Signature of LBHA Service Coordinator: _____ Date: _____

Signature of LBHA Associate Director/Director: _____ Date:

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Application for Financial Assistance to Purchase Medication: Pharmacy Invoice Form

List only the psychotropic medications for which financial assistance is requested. Somatic medications cannot be included. Call the authorized pharmacy listed on the instructions page to get actual costs for each prescription.

Medication	Dosage	Amount per Prescription	Schedule	Cost per Prescription	Amount Requested
				Total Amount Requested	$

Signature of LBHA Service Coordinator: _____Date: _____

Signature of LBHA Director/Designee: _____ Date: _____

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