Request for Bus Tickets/Passes

Client Name:_____ Date Requested: _____ Client DOB: _____

I hereby certify that the above named client is currently eligible to receive Public Mental Health Services as indicated:
BOTH of the Following:

✓ Uninsured or Medicaid Eligible
✓ Qualifying ICD-9 Diagnosis: _____ (please specify)

AND

Adults with a serious mental illness with at least one of the following (check applicable):

__ Homeless or in Shelter Plus Care
__ At risk of, or going into, or will be released from an inpatient hospital stay
__ Residing in Independent Housing and in need of services to retain their housing
__ Being released from a Detention Center
__ Have received services in the public mental health system within the last 2 years

OR

Children & adolescents with serious emotional disturbance with at least one of the following (check applicable):

__ Inpatient psychiatric treatment
__ Treatment in a Residential treatment Center (RTC)
__ An out of home placement due to multiple life stressors
__ Have received services in the public mental health system within the last 2 years

AND that all other resources have been exhausted (check all that apply):

___ Personal Resources ___ Assistance from Family/Friends ___ Other:_____

___ EMT/Med Trans (Call 301-759-5123) to begin screening process - must meet med necessity or financial hardship to access)

Name of Provider/Staff Making Request (please print clearly): _____

Requesting Agency/Office (please print clearly): _____

Signature of Requestor: _____

ALLEGANY COUNTY MENTAL HEALTH SYSTEM'S OFFICE (CSA)
A division of the Allegany County Health Department

Transportation Receipt

Date: _____

Received this date from the Mental Health System's Office (CSA) _____ Allegany Transit Bus Ticket(s). I understand that the tickets are to be utilized **only** by _____ _____. I further agree that any unauthorized usage shall result in immediate revocation of future participation in the Mental Health System's Office (CSA) transportation program.

Client Name (please print clearly): _____

Client Signature:_____

P.O. Box 1745
Cumberland, MD 21501-1745

Telephone (301) 759-5070 Fax (301) 777-5621
T.T.Y. only via MD Relay (800) 735-2258

REV: 10/16/08, 01/03/11, 08/23/11, 05/05/2017