Office on Mental Health
Core Service Agency of Harford County, Inc.

2231 Conowingo Road Suite A
Bel Air, MD 21015
P: 410.803.8726
F: 410.803.8732
www.harfordmentalhealth.org

APPROVED □
DENIED □

Application for Pharmacy Assistance Funds

Applications **must be completed and submitted by the provider**. ***Self-referrals will not be accepted.***
Incomplete applications will not be accepted or processed. Please submit completed pharmacy assistance applications to: omhconsumersupport@harfordmentalhealth.org or via fax at 410-803-8732.

Today's Date:_____ **Applicant's Name:**_____

SS#:_____ **DOB:** _____

Applicant's Address:_____

Phone Number: _____

Prescriber:_____ **Primary Diagnosis:** _____

Provider making request:_____ **Email:**_____

Phone Number: _____

Agency Name & Address: _____

Psychotropic Medications

(*Please include a copy of the script & invoice from pharmacy with this request*):

Medication Name	Dosage	Cost

Describe how Psychotropic medication relates to the treatment of a mental health disorder: __
_____
_____
_____

Does applicant have Medicaid? ☐ Yes ☐ No

(If not, please submit Documentation of Uninsured Eligibility Form)

Amount Requested from CSA: $_____ Amount Applicant Will Pay: $_____

Amount from other resources: $ _____ Name of Source:_____

Total: $_____ (Must total amount of assistance needed)

Pharmacy Name and Address: _____

Pharmacy Telephone and Fax: _____

*******FOR OMH/CSA USE ONLY*******

Date Received:_____ OMH/CSA Authorization Code: CSAHC_____

Approved □ Amount: $_____

Denied □ Reason: _____

Signature:_____ Date:_____

Signature:_____ Date: _____