APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Referral

MaineCare Section 28,
Rehabilitative and Community Support Services
for Children with Cognitive Impairments
and Functional Limitations (RCS)

Date Received in**:** _____

Referral Packet must include:

- ☐ **Parent/Guardian's Signature**
- ☐ **Signed APS Healthcare Release of Information**
- ☐ **Diagnostic Evaluation**
- ☐ **Physician's Letter of Eligibility (Birth – 5)**
- ☐ **Functional Assessment Score Summary Sheet**

This request is for:

- ☐ Specialized Section 28
- ☐ Non-Specialized Section 28
- ☐ School Based Section 28

Individual Requesting Service: _____ Relation to Child: _____

Contact Information

Name: _____ Agency: _____

(Person completing form) Are you the case manager: ☐ Yes ☐ No

Office Location/Address: _____

Phone Number: _____ Ext: _____

Fax Number: _____ Email: _____

Signature of person completing form: _____ Date: _____

Information about Child: Child's Name (spelled as it appears on the MaineCare Card)

First: _____ MI: _____ Last: _____

Gender ☐ Male ☐ Female Race: (optional) _____

DOB: _____ SSN: _____ Maine Care #: _____

Legal address where child will receive services

Street: _____

Town: _____ State _____ Zip: _____ Phone: _____

Child's Primary Language :

Caregiver's Primary Language: _____

Does the family utilize interpreter services: ☐ Yes ☐ No

Name of the interpreter & contact information: _____

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Legal Guardian(s) Name & mailing address

Phone #: Cell:

Shared Custody Name & mailing address

Phone #: Cell:

Guardian(s) Custody

Married ☐ Yes
Sole ☐ Yes
Shared ☐ Yes
Name/Address under Shared Custody
DHHS ☐ Yes
Own ☐ Yes

Diagnosis: (DSM) & Code

1. Code:
2. Code:
3. Code:

Diagnosis: (DC 0-3) & Code

1. Code:
2. Code:
3. Code:

Functional Assessment

Composite Score:
Subscale Scores
(Required when composite Score is < 2 s.d.)
Communications:
Social:
Assessment Tool Name:

Description of Identified Need: (please attach additional sheets as needed)

☐ Yes child is aggressive
Explain:

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Please review the following services and check off those, which are currently provided or have been in the past.

Service	Current	Past	Provider	Frequency	Duration	Active involvement Yes or No	Beneficial Yes or No
Psychiatry/Med Mgt.	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Outpatient Tx	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Hospital	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Mobile Crisis	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Family Therapy	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Home Based Services	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Partial Hospital Program/IOP	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Crisis Unit	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Residential Tx	☐	☐				☐ Y ☐ N	☐ Y ☐ N
School/Preschool	☐	☐				☐ Y ☐ N	☐ Y ☐ N
Other	☐	☐				☐ Y ☐ N	☐ Y ☐ N

Family Preference

The Department is obligated to offer you the first available provider with an ability to begin service. You may identify a preferred provider but this provider may not be the first available to begin the service. Choosing a preferred provider may delay the start of service.

☐ No preference

☐ *Preferred "Name of Provider" _____

☐ Please do not send information to the following provider's _____

*If "Preferred Provider" is selected above, please list the provider name by how it appears in APS CareConnection® system.

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Signatures
Release of Information

As the parent/guardian of this child (or self, when own guardian),

☐ Yes, I agree to release information contained within this application, and my child's RCS Comprehensive Assessment and Individual Treatment Plan, but only to receiving provider agencies as part of the treatment planning process.

☐ Yes, I agree to release information contained within this application, and my child's RCS Comprehensive Assessment and Individual Treatment Plan, between my Target Case Manager and the receiving provider agencies as part of the treatment planning process.

☐ No, I do not agree to release information contained within this application and my child's RCS Comprehensive Assessment and Individual Treatment Plan, to receiving provider agencies as part of the treatment planning process.

My signature below indicates my approval of the above statement

Parent/guardian: _____ Date: _____

Participation in the Service

☐ Yes, I agree to participate with my child in this service.
☐ No, I do not agree to participate with my child in this service.

My signature below indicates my approval of the above statement

Parent/guardian: _____ Date: _____

Please fax or mail this form
With a signed APS Healthcare release of information form to:

Fax: (866)325-4752

Attn: Intake Process
APS Healthcare
600 Sable Oaks Drive, Suite 100
South Portland, ME 04106

APS HEALTHCARE
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Member Name: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

I, _____, hereby authorize
(name and address)

_____
(name and address of organization and/or person making disclosure)

to disclose to _____ and
(name and address of organization and/or person receiving information)

authorize _____
(name and address of organization and/or person disclosing or re-disclosing information)

to disclose to _____
(name and address of organization and/or person receiving disclosed or re-disclosed information)

The following information:

☐ Medical history, examination reports, and medications
☐ Operation reports
☐ X-ray reports
☐ HIV test results
☐ Fitness for duty concerns
☐ Alcohol, drug abuse reports
☐ Other:_____
☐ Laboratory reports
☐ Prescriptions
☐ Consultations
☐ Diagnosis
☐ Results of drug screens
☐ Job performance functions
☐ Hospital records, reports, dates of hospitalization and discharge
☐ Reports of participation and progress and treatment
☐ Discharge plans
☐ Treatment or tests
☐ Copies of all other reports
☐ Mental health records, psychiatric, social, psychological, and other allied health evaluations

Purpose(s) or need(s) for release:
☐ Ongoing diagnosis, treatment planning, social, vocational, fiscal or educational planning
☐ Determining the appropriateness of services being provided and coordination of diagnostic evaluation, treatment planning and/or medical, social, vocational and/or psychological service delivery
☐ Rehabilitation case management of medical condition as a result of a workers' compensation injury
☐ Claims appeal or claims processing
☐ For any lawful purpose
☐ Other

This authorization includes the types of information set forth above generated until the date of signature AND subsequently if generated before: (Provide date): _____.

I understand that individually identified health information ("IIHI") is protected under Federal and/or State confidentiality law. I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will. I may withdraw this authorization to disclose IIHI at any time by written revocation except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of IIHI authorized by this shall cease immediately. If not previously revoked, this authorization will terminate upon ___ year(s) from the date written on this form. A file copy is considered equivalent to the original.
I understand that if the organization authorized to receive the information is not a health plan or health care provider, or a contractor thereof, the released IIHI may no longer be protected by federal privacy regulations. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that APS will [not] receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Guardian or Authorized Representative, (if required, and relationship) Date

Witness: _____

PRINT FORM EMAIL FORM

Patient is: ☐ Minor ☐ Incompetent ☐ Deceased

Legal Authority: ☐ Parent or Legal Guardian ☐ Next of Kin of Deceased

The person signing this authorization is entitled to a copy.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION: PROHIBITION ON REDISCLOSURE. If the information disclosed to you relates to alcohol and other substance abuse treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecue any alcohol or other substance abuse patient.