Referral

MaineCare Section 65,
Home and Community-Based Treatment (HCT)

Referral must include:

☐ **Parent/Guardian's Signature**
☐ **Signed APS Healthcare Release of Information**

Fax/mail this form with signed APS Healthcare release of information form to: Fax: (866)325-4752 OR
APS Healthcare Attn: Intake Process
600 Sable Oaks Drive, Suite 100
South Portland, ME 04106

Please specify:
☐ HCT- General Waitlist
☐ HCT- Preferred Provider Waitlist
(if selecting preferred provider, please see page 4)

Referral Contact Information

Name: _____ Agency: _____
(Person completing form) Are you the case manager: ☐ Yes ☐ No
Office Location/Address: _____
Phone Number: _____ Ext: _____
Fax Number: _____ Email: _____

Child Information: Name (as it appears on the MaineCare Card)

First: _____ MI: _____ Last: _____
Gender ☐ Male ☐ Female
DOB: _____ SSN: _____ Maine Care #: _____
Legal address where child will receive services
Street: _____
City/Town: _____ State _____ Zip: _____ Phone: _____

Child's Primary Language :

Caregiver's Primary Language: _____
Does the family utilize interpreter services: ☐ Yes ☐ No

APS Healthcare

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

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Legal Guardian(s) Name & mailing address Phone #: Cell: **Shared Custody** Name & mailing address Phone #: Cell:	**Guardian(s) Custody** Sole ☐ Yes Shared ☐ Yes Name/Address under Shared Custody DHHS ☐ Yes

Primary Reason for referral: (please attach additional sheets as needed to include *frequency, intensity, and duration of symptoms and behaviors)*

Is the member receiving Outpatient Services? ☐ Yes ☐ No
If yes, please describe how the member's needs are not being met that the level. If no, please discuss why HCT level is required.

Has the member had HCT in the home within six (6) months? ☐ Yes ☐ No
If yes, please discuss why sustainable progress has not been made.

Has the child been involved in the Juvenile Justice System? ☐ Yes ☐ No
(If yes please explain)

Is the youth at risk for out of home treatment or transitioning home from an out of home treatment? ☐ Yes ☐ No
(If yes please explain)

Primary Diagnosis: (Note if DC:0-3)

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Family Preference

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 providers _____

Signatures

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

☐ Yes, I agree to release information contained within this HCT referral, but only to receiving provider agencies as part of the treatment planning process.

☐ Yes, I agree to release information contained within this HCT referral, 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 HCT referral to receiving provider agencies as part of the treatment planning process.

My signature below indicates my approval of the above statement

Parent/Guardian: _____ Date: _____

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: _____

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.