

## 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 3)

**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

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<p><b><u>Legal Guardian(s)</u></b> Name &amp; mailing address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone #: _____ Cell: _____</p> <p><b><u>Shared Custody</u></b> Name &amp; mailing address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone #: _____ Cell: _____</p>	<p><b><u>Guardian(s) Custody</u></b></p> <p>Sole <input type="checkbox"/> Yes</p> <p>Shared <input type="checkbox"/> Yes</p> <p>Name/Address under Shared Custody</p> <p>DHHS <input type="checkbox"/> Yes</p>
<p><b>Primary Reason for referral:</b> (please attach additional sheets as needed to include <i>frequency, intensity, and duration of symptoms and behaviors</i>)</p> <p><b>Is the member receiving Outpatient Services?</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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.</p> <p><b>Has the member had HCT in the home within six (6) months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please discuss why sustainable progress has not been made.</p> <p><b>Has the child been involved in the Juvenile Justice System?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes please explain)</p> <p><b>Is the youth at risk for out of home treatment or transitioning home from an out of home treatment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes please explain)</p> <p><b>Primary Diagnosis:</b> (Note if DC:0-3)</p>	

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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:

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

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 prosecute any alcohol or other substance abuse patient.