

Riverside Community Care

THE HELP YOU NEED CLOSE TO HOME

LIFE SKILLS REFERRAL

Please fill out and return to: Kerry Roberts

DMH-

361 Plantation St.

Worcester, MA 01605

T: 774.420.3104

F: 774.420.3163

kerry.roberts@state.ma.us

1. Client Name:

2. Date of Referral:

3. Date of Birth:

4. Identified Gender

5. Current Address:

6. Telephone Number:

7. Parent/Guardian Address:

Parent 1:

Parent :

Tel.# (H) (W)

Tel.# (H) (W)

8. Guardianship / Custody Status:

Name:

Address:

9. Emergency Information:

10. Presenting Problem: (Be specific re: behaviors)

11. Goals (Life Skills)

Other

12. Entitlements: (Please check appropriate Entitlement)

GRF (General Relief)	()	AFDC	()
SSI (Social Security Income)	()	Other(Please Define)	()

13. Education:

Grade:	School:
Town:	Date of CORE Evaluation:
Date of IEP:	

14. Psychiatric Hospitalizations: Total Number:

Hospital (Most Recent)	Date	Reason for Hospitalization

15. Out – Home – Placements:

Placement	Date

16. DSM Diagnosis:

Date:	Where From:
Code	Diagnosis

17. Symptomatology:

History of any of the following:

(c = Currently, H = History, B = Both)

- | | |
|--------------------------|------------------------|
| Suicidality () | Assaultive () |
| Fire Setting () | Escape Risk () |
| Sexualized Behaviors () | Sexual Abuse () |
| Self-Harm () | Psychotic Symptoms () |

Other (Please Explain) _____

18. DHM application submitted () yes () no

19. Drug / Alcohol Abuse (Be specific around type, frequency, and duration):

20. Prescribed Medications / Known Allergies or Medical Problems:

a. Medications

b. Allergies / Medical Problems

21.. Multigenerational Family History:

(Briefly mention psychiatric, drug / alcohol, or abuse Hx):

22. Criminal Justice History:

23. Contacts: (Include Telephone Number):

A. DMH (Dept. of Mental Health) _____

B. DYS (Dept. of Youth Services) _____

C. DCF (Dept. of Children and Families) _____

D. SPED Liaison (School) _____

E. Therapist _____

F. Psychiatrist _____

G. Other (Please Explain) _____

24. Insurance: Policy #

25. Referral Source:

Name: _____ **Relationship:** _____

Telephone Number: _____

Additional information (to speed referral)

- DMH Application if not already approved or submitted

- Any Clinical Documentation to support Diagnosis (testing, discharge summaries...)

Application for Child/Adolescent Services – Instructions

The Department of Mental Health (DMH) provides services and supports to children and adolescents with serious emotional disturbance and their families to enable them to remain in the community. These services are intended for those youth and their families who need more than an outpatient intervention or medication.

Applications for youth under the age of 18 who request mental health services must include the following completed forms, with parent or legal guardian signatures and dates where indicated:

- Request for Child/Adolescent Services* application
- DMH Service Authorization Determination (page 6)*
- Authorization(s) for Release of Information*

To expedite the determination, DMH encourages applicants to also submit relevant medical and educational information and documents such as:

- Psychiatric assessment* completed by a licensed clinician within the previous six months, and/or
- Hospital admission/discharge reports* if hospitalized during the previous six months
- Copy of the *Individualized Educational Plan (IEP)* if one is in place

While submitting medical and educational information at the time of a request for services is not required, it is strongly recommended the information be submitted at the same time. DMH will need to review such information and will require such information at a later date.

If you are a provider of mental health care and making a referral to DMH, please follow the instructions on page two.

Within seven (7) days of receipt of a *Request for Child/Adolescent Services* application, DMH will contact the parent or other legal guardian by telephone. The purpose of the phone contact will be to:

- Acknowledge DMH's receipt of the *Request for Child/Adolescent Services* application
- Review the determination process
- Confirm that the parent or legal guardian wants to continue the determination process
- Assess the applicant's immediate or emerging needs and respond as appropriate
- Initiate the collection of relevant medical and other information that supports the request for services.

A DMH Clinical Service Authorization Specialist may request, as necessary, a face-to-face meeting with the applicant and/or guardian to further discuss and assess the needs of the child or adolescent and family.

The DMH Area Director or designee in the Area where services are being sought will make decisions regarding service requests upon receiving and reviewing information in accordance with DMH regulations.

Since the availability of DMH services is limited, DMH must prioritize to whom and how those services are provided. DMH regulations establish the criteria to be used to determine who is authorized to receive DMH services and how those services are assigned.

Application materials are available in all DMH Area and Site Offices, acute inpatient psychiatric facilities, in many community programs throughout the Commonwealth and can be downloaded from the DMH website at www.mass.gov/dmh. Applications are available in English. DMH can provide translators for other languages if necessary and provide other assistance as needed.

A completed *Request for Child/Adolescent Services* application, a signed *DMH Service Authorization Determination* form (page 5), and *Authorization for Release of Information* forms must be delivered, mailed or faxed to the DMH Area Office with responsibility for the community where the parent or legal guardian resides at the time of application.

Where to send the application:

Please find your city or town in the list that appears on the following pages and send your application to the respective DMH Office:

Office	Mailing Address	Phone Number
Boston	85 East Newton Street, Boston, MA 02118	(617) 626-9200
Brockton	165 Quincy Street, Brockton, MA 02302	(508) 897-2000
Northampton	1 Prince Street, Northampton, MA 01060	(413) 587-6200
Tewksbury	P.O. Box 387, Tewksbury, MA 01876-0387	(978) 863-5000
Worcester	361 Plantation Street, Worcester, MA 01605	(774) 420-3140

Applications should **NOT** be sent to the DMH Central Office at 25 Staniford Street in Boston. Doing so will result in misdirected applications and may cause delays in the decision process.

Please contact the DMH Information and Referral Line at 1-800-221-0053 (Monday through Friday, 9am – 5pm) if you have questions about the application process or need information about where an application should be sent.

Additional Instructions for Providers of Mental Health Care

A provider of mental health care who makes a referral to DMH must submit relevant clinical information including:

For applicants currently at an inpatient facility

- Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V)
- Any other assessments (e.g. psychosocial, medication, neuropsychological testing, neuropsychological examinations, etc.)
- Hospital Course, including treatment plan

For applicants who currently reside in the community

- Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V)
- Any other assessments (e.g. psychosocial, medication, neuropsychological testing, neuropsychological examinations, etc.)
- Discharge summary, if hospitalized during the previous six months
- Current mental health treatment plan

Providers of mental health care who make a referral to DMH must ensure that signed *Authorization for Release of Information* forms are included for all clinical information submitted with the request for services. The submission of release forms at the time of application for other documents DMH will need to obtain will facilitate the determination process for the applicant. DMH may also request additional clinical information as necessary.

Commonwealth of Massachusetts
REQUEST FOR CHILD/ADOLESCENT SERVICES

Department of Mental Health (DMH)
Effective October 2009 (Revised October 2015)

City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office
Abington	Brockton	Boston - Hyde Park	Boston	Danvers	Tewksbury	Hadley	Northampton
Acton	Tewksbury	Boston-Jamaica Plain	Boston	Dartmouth	Brockton	Halifax	Brockton
Acushnet	Brockton	Boston - Mattapan	Boston	Dedham	Worcester	Hamilton	Tewksbury
Adams	Northampton	Boston - North End	Boston	Deerfield	Northampton	Hampden	Northampton
Agawam	Northampton	Boston - Revere	Boston	Dennis	Brockton	Hancock	Northampton
Alford	Northampton	Boston - Roslindale	Boston	Dennisport	Brockton	Hanover	Brockton
Allston	Boston	Boston - Roxbury	Boston	Dighton	Brockton	Hanson	Brockton
Amesbury	Tewksbury	Boston - Somerville	Boston	Dorchester	Boston	Hardwick	Worcester
Amherst	Northampton	Boston - South End	Boston	Douglas	Worcester	Harvard	Worcester
Andover	Tewksbury	Boston - Southie	Boston	Dover	Worcester	Harwich	Brockton
Aquinnah	Brockton	Boston - W. Roxbury	Boston	Dracut	Tewksbury	Harwichport	Brockton
Arlington	Tewksbury	Boston - Winthrop	Boston	Dudley	Worcester	Hatfield	Northampton
Ashburnham	Worcester	Bourne	Brockton	Dunstable	Tewksbury	Haverhill	Tewksbury
Ashby	Worcester	Boxborough	Tewksbury	Duxbury	Brockton	Hawley	Northampton
Ashfield	Northampton	Boxford	Tewksbury	East Boston	Boston	Heath	Northampton
Ashland	Worcester	Boylston	Worcester	E. Bridgewater	Brockton	Hingham	Brockton
Assonet	Brockton	Bradford	Tewksbury	East Brookfield	Worcester	Hinsdale	Northampton
Athol	Northampton	Braintree	Brockton	E. Longmeadow	Northampton	Holbrook	Brockton
Attleboro	Brockton	Brewster	Brockton	East Sandwich	Brockton	Holden	Worcester
Auburn	Worcester	Bridgewater	Brockton	Eastham	Brockton	Holland	Worcester
Avon	Brockton	Brighton	Boston	Easthampton	Northampton	Holliston	Worcester
Ayer	Worcester	Brimfield	Worcester	Easton	Brockton	Holyoke	Northampton
Back Bay	Boston	Brockton	Brockton	Edgartown	Brockton	Hopedale	Worcester
Baldwinville	Worcester	Brookfield	Worcester	Egremont	Northampton	Hopkinton	Worcester
Barnstable	Brockton	Brookline	Boston	Erving	Northampton	Hubbardston	Worcester
Barre	Worcester	Buckland	Northampton	Essex	Tewksbury	Hudson	Worcester
Beacon Hill	Boston	Burlington	Tewksbury	Everett	Tewksbury	Hull	Brockton
Becket	Northampton	Buzzards Bay	Brockton	Fairhaven	Brockton	Huntington	Northampton
Bedford	Tewksbury	Byfield	Tewksbury	Fall River	Brockton	Hyannis	Brockton
Belchertown	Northampton	Cambridge	Boston	Falmouth	Brockton	Hyde Park	Boston
Bellingham	Worcester	Canton	Worcester	Fenway	Boston	Ipswich	Tewksbury
Belmont	Tewksbury	Carlisle	Tewksbury	Fiskdale	Worcester	Jamaica Plain	Boston
Berkeley	Brockton	Carver	Brockton	Fitchburg	Worcester	Jefferson	Worcester
Berlin	Worcester	Charlemont	Northampton	Florida	Northampton	Kingston	Brockton
Bernardston	Northampton	Charlestown	Boston	Foxborough	Worcester	Lakeville	Brockton
Beverly	Tewksbury	Charlton	Worcester	Framingham	Worcester	Lancaster	Worcester
Billerica	Tewksbury	Chatham	Brockton	Franklin	Worcester	Lanesborough	Northampton
Blackstone	Worcester	Chelmsford	Tewksbury	Freetown	Brockton	Lawrence	Tewksbury
Blandford	Northampton	Chelsea	Boston	Gardner	Worcester	Lee	Northampton
Bolton	Worcester	Cherry Valley	Worcester	Gay Head	Brockton	Leicester	Worcester
Bondsville	Northampton	Cheshire	Northampton	Georgetown	Tewksbury	Lenox	Northampton
Boston - Allston	Boston	Chester	Northampton	Gilbertville	Worcester	Leominster	Worcester
Boston - Back Bay	Boston	Chesterfield	Northampton	Gill	Northampton	Leverett	Northampton
Boston - Beacon Hill	Boston	Chicopee	Northampton	Gloucester	Tewksbury	Lexington	Tewksbury
Boston - Brighton	Boston	Chilmark	Brockton	Goshen	Northampton	Leyden	Northampton
Boston - Brookline	Boston	Clarksburg	Northampton	Gosnold	Brockton	Lincoln	Tewksbury
Boston - Cambridge	Boston	Clinton	Worcester	Grafton	Worcester	Linwood	Worcester
Boston-Charlestown	Boston	Cohasset	Brockton	Granby	Northampton	Littleton	Tewksbury
Boston - Chelsea	Boston	Colrain	Northampton	Granville	Northampton	Longmeadow	Northampton
Boston - Chinatown	Boston	Concord	Tewksbury	Great Barrington	Northampton	Lowell	Tewksbury
Boston - Dorchester	Boston	Conway	Northampton	Green Harbor	Brockton	Ludlow	Northampton
Boston - Downtown	Boston	Cotuit	Brockton	Greenfield	Northampton	Lunenburg	Worcester
Boston - East	Boston	Cumington	Northampton	Groton	Worcester	Lynn	Tewksbury
Boston - Fenway	Boston	Dalton	Northampton	Groveland	Tewksbury	Lynnfield	Tewksbury

Commonwealth of Massachusetts
REQUEST FOR CHILD/ADOLESCENT SERVICES

Department of Mental Health (DMH)
Effective October 2009 (Revised October 2015)

City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office
Malden	Tewksbury	North Truro	Brockton	Sandisfield	Northampton	Wales	Worcester
Manchester	Tewksbury	Northampton	Northampton	Sandwich	Brockton	Walpole	Worcester
Manomet	Brockton	Northborough	Worcester	Saugus	Tewksbury	Waltham	Tewksbury
Mansfield	Brockton	Northbridge	Worcester	Savoy	Northampton	Ware	Northampton
Marblehead	Tewksbury	Northfield	Northampton	Scituate	Brockton	Wareham	Brockton
Marion	Brockton	Norton	Brockton	Seekonk	Brockton	Warren	Worcester
Marlborough	Worcester	Norwell	Brockton	Sharon	Worcester	Warwick	Northampton
Marshfield	Brockton	Norwood	Worcester	Sheffield	Northampton	Washington	Northampton
Marston Mills	Brockton	Oak Bluffs	Brockton	Shelburne	Northampton	Watertown	Tewksbury
Martha's Vineyard	Brockton	Oakham	Worcester	Sherborn	Worcester	Wayland	Worcester
Mashpee	Brockton	Onset	Brockton	Shirley	Worcester	Webster	Worcester
Mattapan	Boston	Orange	Northampton	Shrewsbury	Worcester	Wellesley	Worcester
Mattapoisett	Brockton	Orleans	Brockton	Shutesbury	Northampton	Wellfleet	Brockton
Maynard	Tewksbury	Osterville	Brockton	Somerset	Brockton	Wendell	Northampton
Medfield	Worcester	Otis	Northampton	Somerville	Boston	Wenham	Tewksbury
Medford	Tewksbury	Oxford	Worcester	South Boston	Boston	West Barnstable	Brockton
Medway	Worcester	Palmer	Northampton	South Hadley	Northampton	West Boylston	Worcester
Melrose	Tewksbury	Paxton	Worcester	South Wellfleet	Brockton	West Bridgewater	Brockton
Mendon	Worcester	Peabody	Tewksbury	South Yarmouth	Brockton	West Brookfield	Worcester
Merrimac	Tewksbury	Pelham	Northampton	Southampton	Northampton	West Newbury	Tewksbury
Methuen	Tewksbury	Pembroke	Brockton	Southborough	Worcester	West Roxbury	Boston
Middleborough	Brockton	Pepperell	Worcester	Southbridge	Worcester	West Springfield	Northampton
Middlefield	Northampton	Peru	Northampton	Southwick	Northampton	West Stockbridge	Northampton
Middleton	Tewksbury	Petersham	Northampton	Spencer	Worcester	West Tisbury	Brockton
Milford	Worcester	Phillipston	Northampton	Springfield	Northampton	West Yarmouth	Brockton
Millbury	Worcester	Pittsfield	Northampton	Sterling	Worcester	Westborough	Worcester
Millers Falls	Northampton	Plainfield	Northampton	Stockbridge	Northampton	Westfield	Northampton
Millis	Worcester	Plainville	Worcester	Stoneham	Tewksbury	Westford	Tewksbury
Millville	Worcester	Plymouth	Brockton	Stoughton	Brockton	Westhampton	Northampton
Milton	Brockton	Plympton	Brockton	Stow	Tewksbury	Westminster	Worcester
Monroe	Northampton	Pocasset	Brockton	Sturbridge	Worcester	Weston	Worcester
Monson	Northampton	Princeton	Worcester	Sudbury	Worcester	Westport	Brockton
Montague	Northampton	Provincetown	Brockton	Sunderland	Northampton	Westwood	Worcester
Monterey	Northampton	Quincy	Brockton	Sutton	Worcester	Weymouth	Brockton
Montgomery	Northampton	Randolph	Brockton	Swampscott	Tewksbury	Whately	Northampton
Mt Washington	Northampton	Raynham	Brockton	Swansea	Brockton	White Horse Bch	Brockton
Nahant	Tewksbury	Reading	Tewksbury	Taunton	Brockton	Whitinsville	Worcester
Nantucket	Brockton	Rehoboth	Brockton	Teaticket	Brockton	Whitman	Brockton
Natick	Worcester	Revere	Boston	Templeton	Worcester	Wilbraham	Northampton
Needham	Worcester	Richmond	Northampton	Tewksbury	Tewksbury	Williamsburg	Northampton
New Ashford	Northampton	Rochdale	Worcester	Thorndike	Northampton	Williamstown	Northampton
New Bedford	Brockton	Rochester	Brockton	Three Rivers	Northampton	Wilmington	Tewksbury
New Braintree	Worcester	Rockland	Brockton	Tisbury	Brockton	Winchendon	Worcester
New Marlborough	Northampton	Rockport	Tewksbury	Tolland	Northampton	Winchester	Tewksbury
New Salem	Northampton	Rosindale	Boston	Topsfield	Tewksbury	Windsor	Northampton
Newbury	Tewksbury	Rowe	Northampton	Townsend	Worcester	Winthrop	Boston
Newburyport	Tewksbury	Rowley	Tewksbury	Truro	Brockton	Woburn	Tewksbury
Newton	Worcester	Roxbury	Boston	Turners Falls	Northampton	Wollaston	Brockton
Norfolk	Worcester	Royalston	Northampton	Tyngsborough	Tewksbury	Woods Hole	Brockton
North Adams	Northampton	Russell	Northampton	Tyringham	Northampton	Worcester	Worcester
North Andover	Tewksbury	Rutland	Worcester	Upton	Worcester	Worthington	Northampton
North Attleboro	Brockton	Sagamore	Brockton	Uxbridge	Worcester	Wrentham	Worcester
North Brookfield	Worcester	Salem	Tewksbury	Vineyard Haven	Brockton	Yarmouth	Brockton
North Reading	Tewksbury	Salisbury	Tewksbury	Wakefield	Tewksbury	Yarmouthport	Brockton

Race and Ethnicity Categories

The following categories may be used to complete the “Race” and “Ethnicity” categories on the DMH Application for Services. In filling out the application, please be advised of the following:

This information is requested so that DMH may better provide person-centered services that are culturally and linguistically appropriate. It also helps the Department comply with regulations and standards, and allows for the planning of any unmet service needs.

Persons who are of more than one race or ethnicity are invited to identify as such.

The provision of this information is optional. You may choose whether or not to provide this information. Your decision to do so, or not to do so, will not affect your application for DMH services in any way.

RACE

The following designations come from the federal government:

Race Options
Black OR African American
Asian
Black/Hispanic
American Indian/Alaska Native
Chooses Not To Self-Identify
Other
Native Hawaiian or other Pacific Islander
Two or More Races
Unknown
White/Hispanic
White/Non-Hispanic

ETHNICITY

Ethnicity is defined as the group of people who you are connected to by a common national origin, history, language or customs and cultural experiences. The following are some examples of ethnicity or ethnic groups:

Ethnicity Examples		
Albanian	Greek	Pakistani
American - USA	Guatemalan	Peruvian
Armenian	Haitian	Panamanian
Bhutanese	Hispanic, Other	Polish
Bosnian	Hmong	Portuguese
Brazilian	Honduran	Puerto Rican
Burmese	Indian	Russian
Cambodian	Iranian	Salvadoran
Canadian	Iraqi	Somali
Cape Verdean	Irish	Thai
Chinese	Israeli	Tibetan
Colombian	Italian	Ukrainian
Congolese	Japanese	Unknown
Costa Rican	Korean	Venezuelan
Dominican	Laotian	Vietnamese
Egyptian	Lebanese	West Indian/Caribbean
Eritrean	Mexican	
Ethiopian	Moroccan	Two or More Ethnicities
Filipino	Nigerian	Other
French	Nicaraguan	Chooses Not To Self-Identify

Name _____ SSN _____
(Last) (First) (Middle) (Social Security Number)

Address _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

Birth Date ____ / ____ / ____ Age ____ Gender ____ Race ____ Ethnicity ____
MM DD YYYY (Optional) (Optional)

Does applicant speak English? Yes No

Applicant Preferred Language _____ Are interpreter services needed? Yes No

Parent(s) Name _____

Parent(s) Address _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

How may we contact the Parent(s)? (Please check all that apply and provide phone number/e-mail address)

- Day/Work Phone () _____ May we leave a message? Yes No
- Evening Phone () _____ May we leave a message? Yes No
- Cell Phone () _____ May we leave a message? Yes No
- e-mail _____

Does Parent speak English? Yes No Are interpreter services needed? Yes No

Parent Preferred Language _____

Does Parent have Legal Custody? Yes No Does Parent have Physical Custody? Yes No

If parent does not have legal custody,

Name of Legal Guardian _____ Relationship _____
(Last) (First) (Relationship to Applicant)

Guardian's address _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

How may we contact the Guardian? (Please check all that apply and provide phone number(s) and/or e-mail address.)

- Day/Work Phone () _____ May we leave a message? Yes No
- Evening Phone () _____ May we leave a message? Yes No
- Cell Phone () _____ May we leave a message? Yes No
- e-mail _____

Health Insurance

No health insurance

Application for Health Insurance Pending

Private Insurance: Please specify: _____

Medicaid

If Medicaid, is applicant currently enrolled in a CSA? Yes No Please identify: _____

Medicare/Medicaid

Is applicant currently in a hospital, CBAT or ART? Yes No If yes, where? _____

Is applicant currently homeless? Yes No Involved agency, if any: _____

Is applicant currently on probation? Yes No Unknown If yes, probation officer name _____

Is applicant currently involved with a CHINS? Yes No Unknown

Is applicant involved with another state agency? Yes No Unknown If yes, agency? DCF DYS DDS

DCF Area Office _____ DCF Worker Name _____

DDS/DYS Area Office _____ **DDS/DYS Worker Name** _____

Education/School Information

Is applicant currently in school? Yes No Unknown If yes, school and town/city _____

Who is the responsible Local Educational Agency (LEA)? _____

Does applicant have an IEP (Individualized Education Plan)? Yes No Unknown

If Yes, what type of special education service(s) is the applicant receiving? (Please check all that apply.)

Residential Other: Please specify: _____

Day Unknown

Does applicant have a 504 Accommodation Plan? Yes No Unknown

Primary Mental Health Care Provider: Please indicate who provides regular mental health care to the applicant. If there is no regular source of mental health care, use this section to indicate the most recent source of mental health care.

Primary Mental Health Provider _____ Current provider? Yes No
(Last) (First)

Address _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

Telephone Number () _____ Extension _____

Does applicant have a current psychiatric diagnosis? Yes No Unknown If yes, what is it? _____

Is applicant currently taking any medications? Yes No Unknown If yes, please list all medications: _____

If yes, who is currently prescribing these medications? _____

General Physical Health: Please indicate who provides regular physical health care to the applicant. If there is no regular source of physical health care, use this section to indicate the most recent source of medical care.

Primary Medical Care Provider _____ Current provider? Yes No
(Last) (First)

Telephone Number () _____ Extension _____

Does applicant have any medical problems that require regular care? Yes No Unknown

Has applicant ever had a diagnosis of a neurological problem? Yes No Unknown

If yes, please describe any current medical or neurological problems: _____

Why are you applying for services? (check all that apply and use space below to add your own comments)

- Help stop or prevent the child/adolescent from harming himself/herself or others.
- Help the child/adolescent learn to manage his/her mental health problems so that he/she can make and keep friends, succeed in school, and manage life.
- Help and support the parent/guardian in managing the child/adolescent's mental health symptoms.

What kind of services do you think are needed?

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: _____ Other Name(s): _____

Address: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: _____ Attention: _____ Phone: _____

Street: _____ City/Town: _____ State: _____ Zip: _____

DMH Contact Information:

Name: _____ Phone: _____

Address: _____

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify information to be released:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Evaluations | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Admission Documentation | <input type="checkbox"/> Transfer Summary | <input type="checkbox"/> Assessments & Tests | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> ISPs & IAPs | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultations <i>(include name of consultant)</i> |
| <input type="checkbox"/> Psychiatry Notes | <input type="checkbox"/> Neuropsych Testing | <input type="checkbox"/> Other <i>(specify below)</i> | |

Purpose for the authorization (must check one):

The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

Or

- | | |
|--|--|
| <input type="checkbox"/> Coordinate care | <input type="checkbox"/> Facilitate billing |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Obtain insurance, financial or other benefits |

Other purpose (please specify): _____

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: _____ Other Name(s): _____

Address: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: _____ Attention: _____ Phone: _____

Street: _____ City/Town: _____ State: _____ Zip: _____

DMH Contact Information:

Name: _____ Phone: _____

Address: _____

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify information to be released:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Evaluations | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Admission Documentation | <input type="checkbox"/> Transfer Summary | <input type="checkbox"/> Assessments & Tests | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> ISPs & IAPs | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultations <i>(include name of consultant)</i> |
| <input type="checkbox"/> Psychiatry Notes | <input type="checkbox"/> Neuropsych Testing | <input type="checkbox"/> Other <i>(specify below)</i> | |

Purpose for the authorization (must check one):

The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

Or

Coordinate care Facilitate billing

Referral Obtain insurance, financial or other benefits

Other purpose (please specify): _____

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: _____ Other Name(s): _____

Address: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: _____ Attention: _____ Phone: _____

Street: _____ City/Town: _____ State: _____ Zip: _____

DMH Contact Information:

Name: _____ Phone: _____

Address: _____

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify information to be released:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Evaluations | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Admission Documentation | <input type="checkbox"/> Transfer Summary | <input type="checkbox"/> Assessments & Tests | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> ISPs & IAPs | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultations <i>(include name of consultant)</i> |
| <input type="checkbox"/> Psychiatry Notes | <input type="checkbox"/> Neuropsych Testing | <input type="checkbox"/> Other <i>(specify below)</i> | |

Purpose for the authorization (must check one):

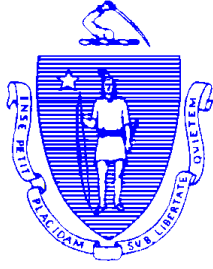
The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

Or

- | | |
|--|--|
| <input type="checkbox"/> Coordinate care | <input type="checkbox"/> Facilitate billing |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Obtain insurance, financial or other benefits |

Other purpose (please specify): _____

A copy of this authorization shall be considered as valid as the original.



Commonwealth of Massachusetts
Department of Mental Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: December 15, 2010
Version 6

Privacy

The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.mass.gov/dmh), and will be available on request. Every privacy notice will be dated.

How Does DMH Use and Disclose PHI?

DMH may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to help make a determination on your application for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with DMH service providers for the purposes of referring you for DMH services and then for coordinating and providing the DMH services you receive.

To obtain payment - Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders

DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
 - **Clergy** – Your religious affiliation may be shared with clergy
 - **To Family and Friends** – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate

- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To EOHHS and/or its agencies, such as MassHealth, DCF, DDS, DYS, DTA and DPH for functions including service delivery, eligibility and program management.
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

*** These requests must be made in writing**

Record Retention

Your individual records relating to DMH provided care and services will be retained at a minimum for 20 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To Contact DMH or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, Phone: 617-626-8160, Fax: 617-626-8131, E-mail: PrivacyOfficer@dmh.state.ma.us. A complaint must be made in writing.

You also may contact a DMH facility's medical records office (for that facility's records), a DMH program director (for that program's records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the **Secretary of Health and Human Services**, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA. 02203.