Referral

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

Referral must include:

☐ **Signed Kepro Release of Information**

This request is for:

☐ **HCT – No Preferred Provider**

☒ **HCT Preferred Provider Requested** (if selecting preferred provider, please see page 3)

Contact Information

Name: _____ Agency: _____

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

Office Location/Address: _____

Agency/Facility NPI Number: _____

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

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

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

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

3. Has the child been involved in the Juvenile Justice System? ☐ Yes ☐ No
   a. If yes, please explain:

4. Is the youth at risk for out of home treatment or transitioning home from an out of home treatment?
   ☐ Yes ☐ No
   a. If yes, please explain:

5. Has the child been suspended or expelled from childcare and/or an educational setting?
   ☐ Yes ☐ No
   a. If yes, please provide the date:

6. When is the family available to be served? ☐ Morning ☐ Afternoon ☐ Evening

7. Is the member's need for service primarily due to their Intellectual Disability/Developmental Disability diagnosis?
   ☐ Yes ☐ No

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8. When is the family available to be served? ☐ Morning ☐ Afternoon ☐ Evening
9. Is member interested in telehealth? ☐ Yes ☐ No
10. Does member have technology to participate in telehealth? ☐ Yes ☐ No
11. Is member open to telehealth for some of the service or all of the service?
    ☐ Some of the service ☐ All of the service
12. Is this request a result of remote learning? ☐ Yes ☐ No
    a. Please explain:
13. Is member/family interested in clinician only HCT services? ☐ Yes ☐ No

Family Preference

You may identify one Preferred Provider, but this provider may not be the first available to begin the service. Please select if you would like to wait for the Preferred Provider or work with the first available Provider, and initial (Guardian)

☒ I would like to wait for a Preferred Provider. _____ (initials)Preferred Agency: Allied Community Services Lewiston

☐ I will work with the first available Provider. _____ (initials)

☐ Please do not send information to the following providers _____

Upload the Referral and Release in the Kepro Atrezzo Provider Portal. For instructions: www.QualityCareforMe.com

Fax: (866)325-4752

KEPRO
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 Allied Community Services LLC, 130 East Ave. Suite 101 Lewiston, ME 04240 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.