

Referral

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

Referral Packet must include:

- Signed KEPRO Release of Information**
- Diagnostic Information** (page 2)
- Physician's Letter of Eligibility (Birth – 5)**
- Functional Assessment Scores, date** (page 2)

This request is for:

- Specialized Section 28- Community**
- Non-Specialized Section 28- Community**
- Specialized Section 28- School-based**
- Non-Specialized Section 28- School-based**

Individual Requesting Service: _____

Relation to Child: _____

<u>Contact Information</u>	
Name: _____	Agency: _____
(Person completing form) Are you the case manager: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Office Location/Address: _____	
Phone Number: _____	Ext: _____
Fax Number: _____	Email: _____
Signature of person completing form: _____	Date: _____

<u>Information about Child: Child's Name (spelled as it appears on the MaineCare Card)</u>			
First: _____	MI: _____	Last: _____	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: (optional) _____		
DOB: _____	SSN: _____	Maine Care #: _____	
<u>Legal address where child will receive services</u>			
Street: _____			
Town: _____	State _____	Zip: _____	Phone: _____

<u>Child's Primary Language :</u>	
Caregiver's Primary Language: _____	
Does the family utilize interpreter services: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of the interpreter & contact information: _____	

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<p><u>Legal Guardian(s)</u> Name & mailing address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone #: _____ Cell: _____</p> <p><u>Shared Custody</u> Name & mailing address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone #: _____ Cell: _____</p>	<p><u>Guardian(s) Custody</u></p> <p>Married <input type="checkbox"/> Yes</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>Own <input type="checkbox"/> Yes</p>
<p><u>Diagnosis: (DSM) & Code</u> Date: _____</p> <p>1. _____ Code: _____</p> <p>2. _____ Code: _____</p> <p>3. _____ Code: _____</p> <p><u>Diagnosis: (DC 0-3) & Code</u> Date: _____</p> <p>1. _____ Code: _____</p> <p>2. _____ Code: _____</p> <p>3. _____ Code: _____</p> <p>Diagnosis provided by, and credentials:</p>	<p><u>Functional Assessment</u> DATE: _____</p> <p>Composite Score: _____</p> <p>Subscale Scores</p> <p>(Required when composite Score is < 2 s.d.)</p> <p>Communications: _____</p> <p>Social: _____</p> <p>Assessment Tool</p> <p>Name: _____</p> <p>Assessment completed by, and credentials:</p>
<p>Description of Identified Need: (please attach additional sheets as needed)</p> <p><input type="checkbox"/> Yes child is aggressive</p> <p>Explain:</p>	

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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.	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Outpatient Tx	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Hospital	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Mobile Crisis	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Home Based Services	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Partial Hospital Program/IOP	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Crisis Unit	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Residential Tx	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
School/Preschool	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Other	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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, have an opportunity to review the first available Provider, or work with the first available Provider, and initial (Guardian)

- *Preferred "Name of Provider" _____
- I would like to wait for this Preferred Provider. _____ (initials)
- I would like to review the first available Provider. _____ (initials)
- I will work with the first available Provider. _____ (initials)
- Please do not send information to the following providers _____

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 _____ 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 KEPRO 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.