



DEPARTMENT OF HEALTH ADULT MENTAL HEALTH DIVISION REFERRAL FORM



1. AGENCY REFERRING TO

Name: _____

Address: _____ Phone No.: _____

_____ Fax No.: _____

City State Zip

2. SERVICE REFERRING TO: REPRESENTATIVE PAYEE SERVICES

3. REFERRING AGENCY

Name: _____

Address: _____ Phone No.: _____

_____ Fax No.: _____

City State Zip

Name of Contact Person: _____ Phone No.: _____

4. CONSUMER DEMOGRAPHIC INFORMATION

Name: _____ AMHD Ref. No.: _____

Gender: Male Female Birth Date: _____ Age: _____

Type of Current Housing (i.e., 24 HR group home, E-ARCH, homeless, etc.): _____

Address: _____ Home Ph. No.: _____

If homeless, indicate where the consumer can be found _____ Cell Ph. No.: _____

City State Zip

5. LEGAL GUARDIAN (if applicable)

Name: _____ Relationship: _____

Address: _____ Phone No.: _____

City State Zip

6. DIAGNOSIS

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

7. ELIGIBILITY

The consumer has been determined eligible for AMHD services: Yes No

8. FORENSICS

Legal Status: Conditional Release Other (specify): _____
Include a copy of the current conditional release or other current orders, if applicable.

Court Date (if applicable): _____

Forensic Coordinator Name: _____ Phone No.: _____

Parole/Probation Officer Name: _____ Phone No.: _____

9. HOSPITALIZED CONSUMERS (if applicable)

Name of Hospital: _____

Discharge Meeting Date: _____ Discharge Date: _____

10. HEALTH INSURANCE

Name of Health Insurance Company: _____ Insurance Card No.: _____
(i.e., HMSA, Kaiser, etc.)

11. INCOME

Monthly Income: \$ _____

Source of Income (i.e., work, SSI, SSDI, DHS, etc.): _____

Other Assets (i.e., savings, etc): _____

12. PSYCHIATRIST

Name: _____

Address: _____ Phone No.: _____

_____ Fax No.: _____
City State Zip

13. PRIMARY CARE PHYSICIAN (PCP)

Name: _____

Address: _____ Phone No.: _____

_____ Fax No.: _____
City State Zip

14. CASE MANAGEMENT (CM) / ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM INFORMATION

Agency Name: _____

CM/ACT Team Name: _____ Phone No.: _____

CM/ACT Team Address: _____ Fax No.: _____

City State Zip

15. HOUSING

Is housing needed? Yes No

Does the consumer have a Sec. 8 rental subsidy? Yes No

If referring for housing, indicate what level:
check only one (1) level

24 Hour Group Home
 8-16 Hour Group Home
 Semi-Independent Group Home
 Support Housing
 Shelter Plus Care

If referring for housing, does the consumer require an accessible home or reasonable accommodation? Yes No

If yes, please describe what the consumer needs: _____

16. CITIZENSHIP

Citizenship Status: US Other (specify): _____ Unknown

17. TO BE COMPLETED FOR REFERRALS TO THE KALIHI PALAMA COMMUNITY FITNESS RESTORATION PROGRAM (KFFT)

a. Current legal charges: _____

b. Legal Status (*check the status that applies*): 704-404
 704-406
 Other, specify: _____

c. Order to Treat: Yes No

d. Advance MH Directive: Yes No

e. History of Violence: Yes No

If yes, date of last/most recent physically aggressive, assaultive behavior: _____

If yes, date of last/most recent threatening behavior: _____

f. Risk of Suicide: Previous suicide attempt: Yes No
If yes, date of last/most recent suicide attempt: _____
Suicidal ideation: Yes No

g. Elopement Risk: Previous AWOL/AWA: Yes No
If yes, date of last/most recent episode of AWOL/AWA: _____

h. Current or previous participation in fitness classes: Yes No

18. INTERPRETER SERVICES

Does the consumer need an interpreter? Yes No

If yes, what language: _____

19. REP PAYEE SERVICES

Does the consumer have a Rep Payee? Yes No

If yes, name of Rep Payee: _____ Phone No.: _____

20. OTHER CURRENT SERVICES

Indicate any services the consumer is currently utilizing: Peer Coach
 Respite
 CRF - amount owed: \$ _____
 CBI (includes 1:1 wrap)
 Clubhouse
 DVR

21. PLEASE INCLUDE THE FOLLOWING DOCUMENTS:

- Consent to release information
- Master Recovery Plan (current)
- Most recent psychiatric evaluation with multiaxial diagnosis which is signed and dated
- Medical Problem List (include proof of PPD)
- Conditional Release or other Current Court Order (if applicable)
- HCR 20 (if applicable)
- Homeless certification (if referring for housing and if applicable)
- Copy of the order naming the guardian. (if #5 applies)

Complete #22 only if you are referring to a service listed in a, b, c, d or e below. If the service you are referring to is not listed in #22, go to #23.

22. PLEASE INCLUDE THE DOCUMENTS FOR THE FOLLOWING SERVICES, IF AVAILABLE.

Please note: This is in addition to the documents required in #21

- a. Specialized Residential Treatment, Day Treatment, Intensive Outpatient Hospital, E-ARCH:
- Nursing Assessment (most recent)
 - Psychosocial Assessment
 - Risk Assessment
 - LOCUS (most recent)
 - Psychological Testing
 - Substance Abuse Assessment
 - Medication Sheet
 - Medical History and Physical (completed within one year of referral date and includes Rubella Titer/proof of immunizations, PPD)
 - Narrative update that includes presenting problem, precipitating events and justification for the service
 - Special diet requirements
 - Dental needs
 - Required for referrals to Specialized Residential Treatment: What is the current discharge plan upon completion of the program.

b. Hale Imua

- Nursing Assessment (most recent)
- Psychosocial Assessment
- Risk Assessment
- Psychological Testing
- Substance Abuse Assessment
- Medication Sheet
- Medical History and Physical (completed within one year of referral date and includes Rubella Titer/proof of immunizations, PPD)
- Special diet requirements
- Dental needs
- LOCUS (most recent)

c. KFIT

- Current psychiatric routine medications (name, strength/dosage, route, schedule)
- Current PRN medications. Include information on when the last PRN dosage was given.
- Add any medications being taken for medical problems listed on the medical problem list in #21.
- LOCUS (most recent)

d. ACT, CBCM, and Outpatient Treatment

- Nursing Assessment (most recent)
- Psychosocial Assessment
- Risk Assessment
- LOCUS (most recent)
- Psychological Testing
- Substance Abuse Assessment
- Medication Sheet
- Medical History and Physical (most current)
- Dental needs

e. PSR

- Nursing Assessment (most recent)
- Psychosocial Assessment
- Risk Assessment
- LOCUS (most recent)
- Substance Abuse Assessment
- Medication Sheet
- Medical History and Physical (completed within one year of referral date and includes Rubella Titer/proof of immunizations, PPD)
- Narrative update that includes presenting problem, precipitating events and justification for the service

23. REFERRAL FORM COMPLETED BY:

Print Name

Signature

Date: _____

24. To be completed by the program receiving the referral.

PROVIDER DECISION FORM

To: _____ FROM: _____
Referring Agency *Provider and Type of Service*

CONSUMER NAME: _____

DOB: _____ AMHD REF#: _____

Date Referral Received: _____

Date Decision Rendered: Accepted Denied

Service Referred to (POS Provider): _____

If consumer was denied for this service, please complete the rest of this form

Current Diagnosis: Axis I: _____

Axis II: _____

Axis III: _____

Reason for Denial of Referral:

- Consumer refused service
- Does not meet criteria for this service (Please provide explanation):

Consumer may be accepted in the future under the following circumstances:

It is recommended that this consumer pursue alternative placement/treatment with another provider or at another level such as:

Medical/Clinical Director Review: _____
Print Name

Signature

Date: _____

Administrative Executive Review: _____
Print Name

Signature

Date: _____

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Representative Payee Consumer Referral Form

Consumers Name: _____ Alias: _____
Last First M.I.

Social Security Number: _____ Birthdate: _____

Mothers Maiden Name: _____

Place of Birth: _____

UM Auth: Yes No UM Authorization Number: _____

Sex: M F Veteran: Yes No Marital Status: M S D W Current Benefit Status: SSI SSDI VA FS
(Check all that apply)

Medical Insurance & #: _____

Citizenship: _____ Ethnicity: _____

DSM-IV Diagnosis: _____

SSA Contact: _____ Phone#: _____ ext: _____

Unit: _____ Fax #: _____

DHS Contact: _____ Phone#: _____ ext: _____

Unit: _____ Fax#: _____

Current Payee Status: _____

Consumer Recent Address: _____

PHONE #: _____ Moved In: _____ Deposit Paid: _____

Landlord Address: _____

Prior: From _____ To _____

Prior: From _____ To _____

Consumers Signature: _____ Date

Case Manager Signature Agency Date

Representative Payee Signature

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REPRESENTATIVE PAYEE REFERRAL

Documents Required

To ensure that the Helping Hands Hawaii Representative Payee is kept abreast of Clients requiring Rep Payee services, please provide the following documents. These documents are to be given to the Rep payee upon initiation of Rep Payee services (referral) and ongoing.

It is understood that Rep Payee is NOT the Case Manager, however, it is important to provide accurate information on your client's behalf to Social Security.

Documents Required (copies are acceptable)

Rep Payee Consumer Referral Form
Rep Payee & Consumer Responsibilities
Authorization to Release/Obtain Confidential Information
Statement of Patients' Capability to Manage Benefits (if needed)
Demographics
Birth Certificates
Social Security Card
Valid I.D. with Picture
Medical Insurance Card(s)
DHS Award Letters
VA Award Letters
UM Authorization for Rep Payee Services

Please advise of any prior aggressive behavior:

Case Manager's Printed Name

Agency

Case Manager's Signature

Contact Number

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Representative Payee Program

Authorization to Release/Obtain Confidential Information

Consumer Name: _____

SSN: _____

I, _____ hereby agree that the Representative Payee Program may release/obtain confidential information regarding me, the undersigned, to/from the following organization or individual:

Social Security Administration (SSA), Department of Human Services (DHS), Department of Health, Adult Mental Health Division, Landlord, Bill Collectors, Telephone Service Companies, Electric Service Companies, Cable Service Providers, Medical Providers and all other pertinent financial service providers.

_____ Helping Hands Hawaii 2100 N Nimitz Hwy Honolulu, HI 96819

(Name and Address of Organization/Individual)

Purpose of release/obtain of information: Financial Advising

Specific information to release/obtain: Award letters, Benefit Information, rent/bills due etc.

I understand that my records are protected under the Federal Confidentiality Regulation and cannot be released without my written consent, unless otherwise provided for in writing, at any time, except to the extent that action has been taken, in reliance thereon.

The information released/obtained may be in written or verbal form. This consent has been made freely, voluntarily and without coercion.

If not earlier revoked, this consent expires the day my Representative Payee account is closed.

Consumer's Signature

Date

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Representative Payee and Consumer Responsibilities

1. Consumers will follow all rules and guidelines established with Rep Payee and Case Manager in treatment plan.
2. You, the Consumer, Case Manager and Representative Payee will agree on a monthly budget. (allocation of your money). The budget must be followed. No exceptions. If you need to make changes to your budget, please meet with your Case Manager.
3. See below for more information:

<i>Description</i>	<i>Action</i>	<i>Remarks</i>
Weekly Allowance	Your Case Manager will give to you on a weekly basis (Monday)	OR as discussed with your Case Manager.
Monthly Allowance	Your Case Manager will give to you on the First of the Month.	OR as discussed with your Case Manager.
Undistributed Allowance	Case Manager will return to Rep Payee, to redeposit into your account.	
Need Extra Money (not on budget) '.	If approved by Case Manager, money will come from your savings	NO borrowing or request for a loan or advance on allowance or extra money.
Request Check for Extra Money (if approved by Case Manager)	Your Case Manager will submit a Check Request to Rep Payee Office	Takes up to 7 days to process
If you borrow money	Your Case Manager will deduct the money you owe from your allowance	

- A consumer who is under the influence or drugs, alcohol, inhalants or other chemicals will NOT receive any allowance or extra funds.
4. The Representative Payee will work with Social Security Administration (SSA) to complete the necessary papers to establish the relationship between you, and the Representative Payee Program. The Representative Payee will report all updated Consumer information to SSA, and complete any reports required by SSA on behalf of you the Consumer for the entire time you are involved with the Representative Payee program.
 5. The Representative Payee will deposit your income (benefits) into a non interest bearing account in the Representative Payee MAS 90 log of accounts. All of your expenses and withdrawals on your behalf will be taken from your Representative Payee account.
 6. You, the Consumer have the right to check your account balance during normal business hours and request a print out of your account to be sent to you.

I understand that I must follow the above guidelines to be in the program, and I agree to become a participant in the Representative Payee Program.

Name (Print) _____ Signature _____ Date _____

Case Manager Name _____ Signature _____

Representative Payee _____ Signature _____

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HELPING HANDS HAWAII
2100 N Nimitz Highway
Honolulu, Hawaii 96819

NOTICE OF PRIVACY PRACTICES *Effective April 14, 2003*

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

..

We understand that your health information is personal and have always taken measures to ensure the confidentiality of the health information of our clients.

We are required by federal law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. We are also required by federal law to comply with the terms of this Notice.

This Notice describes how we will use and disclose your health information. The policies outlined in this Notice apply to all of your health information generated by Helping Hands Hawaii, whether recorded in your medical record, invoices, payment forms, videotapes or other Ways. Similarly, these policies apply to the health information gathered from other agencies by any health care professional, employee or volunteer who participates in your care.

When this Notice refers to "we" or "us", it is referring solely to Helping Hands Hawaii and its core behavioral health programs.

USES AND DISCLOSURE OF YOUR HEALTH INFORMATION

1. In some circumstances we are permitted or required to use or disclose your health information without obtaining your prior authorization and without offering you the opportunity to object. These circumstances include:

a. Uses or disclosures for purposes relating to treatment, payment and health care operations:

Treatment: We may use or disclose your health information for the purpose of providing, or allowing others to provide, treatment to you. An example would be if your primary care physician discloses your health information to another doctor for the purpose of a consultation. Also, we may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment: We may use and/or disclose your health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you. For example, we may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing our claim for the health care services provided to you.

Health Care Options: We may use and/or disclose your information for the purposes of our day-to-day operations and functions. We may also disclose your information to another covered entity to allow it to perform its day-to-day functions, but only to the extent that we both have a relationship with you. For example, we may compile your health information: along with that of other patients, in order to allow our health care professionals to review that information and make suggestions concerning how to improve the quality of care provided by us. Also, we may contact you as part of our efforts to raise funds for the Agency. All fundraising communications will include information about how you may opt out of future fundraising communications.

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- b. To create material(s) that originally had any identifying Information concerning you, deleted from the final material(s);
 - c. When required by law;
 - d. For public health purposes;
 - e. To disclose information about victims of abuse, neglect or domestic violence;
 - f. For health oversight activities, such as audits or civil, administrative or criminal investigations;
 - g. For judicial or administrative proceedings;
 - h. For law enforcement purposes;
 - i. To assist coroners, medical examiners or funeral directors with their official duties;
 - j. To facilitate organ, eye or tissue donation;
 - k. For certain research projects that have been evaluated and approved through a research approval process that takes into account consumer's need for privacy;
 - l. To avert a serious threat to health or safety;
 - m. For specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and
 - n. For workers' compensation purposes, as permitted by law.
2. We may also use or disclose your health information in the following circumstances. However, except in emergency situations, we will inform you of our intended action prior to making any such uses and disclosures and will, at that time, offer you the opportunity to object.
- a. **Directories:** We may maintain a directory of consumers that includes your name and location within the agency, your religious designation, and information about your condition in general terms that will not communicate specific medical information about you.
 - b. **Notifications:** We may disclose to your relatives or close personal friends any health information that is directly related to that person's involvement in the provision of, or payment for, your care. We may also use and disclose your health information for the purpose of locating and, notifying your relatives or close personal friends of your location and general condition or death, and to agencies that are involved in those tasks during disaster situations.

Except as described above, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, In writing, unless we have taken action in reliance upon your prior authorization.

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YOUR RIGHTS

1. To Request Restrictions: You have the right to request restrictions on the use and disclosure of your health information for treatment, payment or health care operations purposes or notification purposes. We are not required to agree to your request. If we do agree to a restriction, we will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, submit a written request to the contact person listed on the final page of this Notice.
2. To Limit Communications: You have the right to receive confidential communications about your own health information by alternative means or at alternative locations. This means that you may, for example, designate that we contact you only via e-mail, or at work rather than home. To request communications via alternative means or at alternative locations, you must submit a written request to the contact person listed on the final page of this notice. All reasonable requests will be granted.
3. To Access and Copy Health Information: You have the right to inspect and copy any health information about you other than psychotherapy notes; information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to the contact person listed on, the final page of this Notice. If you requested copies, you will be charged our regular fee for copying and mailing the requested information.

Despite your general right to access your Protected Health Information, access may be denied in some limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information

In addition, access may be denied if (1) access to the information in question is reasonably likely to endanger the life and physical safety of you or anyone else, (2) the information makes reference to another person and your access would reasonably be likely to cause harm to the person, or (3) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause-substantial harm to the patient or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a health care professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.

4. To Request Amendment: You may request that your health information be amended. Your request may be denied if the information in question: was not created by us (unless you show that the original source of the information is no longer available to seek amendment from), is not part of our records, is not the type of information that would be available to you for inspection or copying (for example, psychotherapy notes), or is accurate and complete. If your request to amend your health information is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distribute with all future disclosures of the information to which it relates. Requests to amend health information must be submitted in writing to the Contact listed on the final page of this Notice.
5. To an Accounting of Disclosures: You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (1) disclosures made for the purpose of carrying out treatment, payment or health care operations, (2) disclosures made to you, (3) disclosures of information maintained in our consumer directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (4) disclosures for national security or intelligence purposes, (5) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (6) disclosures that occurred prior to April 14, 2003 (or the date of this notice whichever is earlier), (7) disclosures made pursuant to an authorization signed by you, (8) disclosures that are part of a limited data set, (9) disclosures that are incidental to another permissible use or disclosure, or (10) disclosures made to a health oversight agency or law enforcement official; but only if the Agency or official asks us not to account to you for such disclosures and

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only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosures, submit a written request to the Contact listed on the final page of this Notice.

6. To a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice upon request.

OUR DUTIES

1. We are required by law to maintain the privacy of your health information and to provide you with this Notice of our legal duties and privacy practices.
2. We are required to abide by the' terms of this Notice. We reserve the right to change the terms of this Notice and to make those changes applicable to all health information that we maintain. Any changes to this Notice will be posted on our *website* and at our *facility*; and will be available from us upon request.

COMPLAINTS

You can complain to us and to the Secretary of the federal department of Health and Human Services if you believe your privacy rights have been violated. To lodge a complaint with us, please file a written complaint with the contact person named below. This contact person will also provide you with further information about our privacy policies upon request. No action, will be taken against you for filing a complaint.

CONTACT PERSON:

Stanley Luke, PhD.
(808) 440-3861
Helping Hands Hawaii
2100 N Nimitz Highway
Honolulu, Hawaii 96819

Privacy Officer:

Brian Schatz
(808) 440-3820
Helping Hands Hawaii
2100 N Nimitz Highway
Honolulu, Hawaii 96819

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Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. The Notice describes:
how my health information may be used or disclosed. I, understand that I should
read it carefully. I am aware that the Notice maybe changed at anytime. I may
obtain a revised copy of the Notice by calling 440~3861; on this Agency's
website at helpinghandshawaii.org, or by requesting one at this Agency's office.

(Signature)

Date

(Print Name)

As the legal representative of the above individual, I acknowledge receipt of the
Notice on his or her behalf.

(Signature of Legal Representative)

(Relationship)

(Print Name)

Date

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Representative Payee Consumer Referral Form

The Representative Payee department understands that some of the information on the referral form cannot be answered, however, the following **MUST** be included to enter our program and are requirements before acceptance:

- Consumer's Name (Last, First, Middle, Initial and Alias if applicable)
- Social Security Number
- Date of Birth
- Mother's Maiden Name
- Place of Birth (City and State or Country)
- Gender
- Marital Status
- Medical Insurance
- Citizenship
- Ethnicity
- Diagnosis
- Consumer Address
- Consumer Signature
- CM Signature

This information is needed to communicate with Social Security and is a requirement under CARF. Do not leave any space blank, if the information is unknown, please write "unknown".

Documents Required

Copies are acceptable for the documents that are required. Please advise the staff of any prior behavioral conflicts so we can be prepared and take necessary precautions.

The following are the documents that are necessary to enter the program:

- Rep Payee Consumer Referral Form
- Rep Payee & Consumer Responsibilities
- Authorization to release/obtain confidential information
- Medical Insurance Cards
- NPP Acknowledgement

The other documents listed on the form are also required but can be turned in at a later time if necessary.

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Authorization to release/obtain information

The consumer **MUST** *sign* this form. The only exception made to this rule is that the consumer has a guardian to sign on his/her behalf.

Representative Payee & Consumer Responsibilities

The guidelines for our program are explained on this form. The consumer **MUST** sign this form as well, unless the consumer has a guardian to sign on his/her behalf.

Acknowledgement of Notice of Privacy Practices

In compliance with HIPAA, this form must be signed by the consumer. A handout of our Privacy Practices will be given to every consumer in our program.

Other Forms

- Budget
- Change of Address
- SSA-787
- Check Request