Care Coordination/Request for Services Cover Sheet

Send this cover sheet to CHOICES Intake with the completed Request for Services Packet

DATE SENT:

NUMBER OF PAGES (*including mandatory forms*):

CONSUMER

Last Name:

First Name:

Date of Birth:

or affix label here

Additional information may be requested to assess program eligibility. If you are unclear where to refer the person, please read the enclosed information about the referral process. If you have additional questions, or wish to clarify the type of information we need, please call us at (907) 333 – 4343

We will acknowledge this referral by completing the "Acknowledgement" section below and return this cover sheet by fax, email or mail

ALL COMPLETE REFERRAL PACKETS MUST INCLUDE:

All of the following in addition to complete Universal Referral Form (pages 6 - 7)

- ☐ This Cover Sheet (page 1)
- ☐ Authorization for Re-Release of Information (page 5)
- ☐ Prescreening Protocol (page 4)
- ☐ Valid client contact information/location (page 6)

At least one of the following:

- ☐ Service Coordination Plan
- ☐ Living Arrangements Profile
- ☐ Health Behaviors Profile
- ☐ Health Conditions Profile
- ☐ Psychosocial Profile
- ☐ Medication Record
- ☐ Functional Assessment Summary
- ☐ Functional Profile
- ☐ Other

AGENCY/PROVIDER SENDING REFERRAL:

Referring Agency/Program:

Referring Worker's Name:

Contact Phone:

Fax:

Referring Worker E-mail:

REFERRAL TO:

CHOICES, Inc.

Intake Coordinator & Client Records

1231 Gambell Street, Suite 300, Anchorage, AK 99501

FAX: (907) 333 – 4383 | **Phone** (907) 333 – 4343

**If choosing to communicate via email, please ensure compliance to HIPAA Privacy Rule and confidentiality requirements. Email may be used between providers and referring parties as long as no client information is included unless encryption is used. This referral form should never be sent via email unless encrypted.*

TYPE OF REFERRAL *(CHECK ALL THAT APPLY)*

- ☐ AOT
- ☐ Potential AOT
- ☐ Acute Inpatient Unit
- ☐ Psychiatric Emergency Unit
- ☐ Mobile Crisis Teams
- ☐ Mental Health Courts
- ☐ Res. Treatment Facilities
- ☐ CMHS
- ☐ Psych. Outpatient Residential

PRIORITY

- ☐ Routine - attend in date order *(may include consumer being placed on waiting list)*
- ☐ Urgent - cannot wait *(consult the service by phone before forwarding this referral)*

REFERRAL ACKNOWLEDGEMENT

Please be advised that the above referral has been received and:

- ☐ **The referral is accepted. Estimated date of assessment / admission / first visit:**
- ☐ **The referral is not proceeding for the following reason(s):**
  - ☐ Consumer declining
  - ☐ Waiting list time inappropriate for consumer
  - ☐ Ineligible for services
  - ☐ Inappropriate referral
  - ☐ Other

Comments and any further actions undertaken (if referral is not proceeding):

Date Acknowledged: ______________________ **Name:** ______________________

Prescreening Protocol

Mandatory for Determination of Eligibility for Services.

CHOICES, INC. WILL NO LONGER BE ACCEPTING REFERRALS FOR SERVICES WITHOUT PREDETERMINATION REVIEW.

☐ **MUST BE EIGHTEEN (18) YEARS OF AGE OR OLDER**

☐ **MUST BE FUNCTIONALLY DISABLED** as a result of a medically determined mental illness, which is likely to continue for a prolonged period and is evidenced by a primary psychiatric diagnosis that fits the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). This must be other than (*for ACT*), or in addition to (*for ICM and Peer Support*), a diagnosis of alcohol, drug disorders, organic brain syndromes, developmental disabilities, or social conditions. **(List diagnosis name and code in the space provided.)**

Primary: ____________________

Secondary: ____________________

☐ **MUST ALSO MEET AT LEAST TWO OF THE FOLLOWING:**

A. ☐ ***Substantial, marked functional impairment in three (3) or more of the following areas due to a designated mental health need over the past twelve months on a continuous or intermittent basis:***

1. ☐ Self-care
2. ☐ Social functioning
3. ☐ Activities of daily living
4. ☐ Economic self-sufficiency
5. ☐ Self-direction
6. ☐ Ability to concentrate (resulting in failure to complete tasks in a timely manner in work, home or school settings)

B. ☐ ***Designated mental health need over the past twelve months on a continuous or intermittent basis***

C. ☐ ***Permanent eligibility (at least one):***

1. ☐ One six-month stay in an inpatient psychiatric unit, or two of any length
2. ☐ SSI/SSDI recipient due to mental health needs
3. ☐ Resident of a State-operated or licensed home
4. ☐ Other:

D. ☐ ***Categorical eligibility (at least one):***

1. ☐ Homeless, or homeless and living in a designated shelter
2. ☐ Inpatient in a State-operated psychiatric facility scheduled for discharge
3. ☐ Other

E. ☐ ***Reliance on psychiatric treatment, rehabilitation and/or supports.***

A documented history shows that the individual, at some prior time, met the threshold of A or B above, but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications, which may control certain primary manifestations of mental disorders (e.g. hallucinations) but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings, which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.

If the predetermination review indicates this person is appropriate for referral to CHOICES, Inc and our programs, please continue with the application.

CERTIFICATION (MUST BE SIGNED BY THE REFERRING PROVIDER)

I certify that this individual (enter name), ______________________________, who is eighteen years of age or older, is functionally disabled due to mental health needs, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the eligibility requirements.

Print Name of Referent/Person Completing This Form	*Title*
Signature	*Date*

Authorization for Re-Release of Information

Must be completed for all clients referred to CHOICES, Inc.

This authorization must be completed by the client or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. No HIV or HIV related information will be re-released.

Referrals that do not have authorization from the client may further delay processing of your request for services.

PART I: AUTHORIZATION TO RE-RELEASE INFORMATION

Description of Information to be Used/Disclosed:

You have been referred for Intensive Case Management (ICM) or Assertive Community Treatment (ACT) services at CHOICES, Inc.
In order to review your referral, CHOICES, Inc. Intake Coordinator must review information from your referral source (including your psychiatric, psychosocial and other health care related evaluations) to discuss this application so that the right services may be provided for you.

If you are found eligible for ICM or ACT services, CHOICES, Inc. will then need to share information with the ICM or ACT clinical team.
The information that will need to be shared with the assigned program may include your educational, medical and mental health assessments, including psychiatric evaluations, psychosocial assessments, medical exams, TB test results and discharge reports. This information should be included with the Referral Form.

On this authorization form, you are being asked to consent to have your psychiatric, psychosocial and other health care related evaluations released by your referral source to CHOICES, Inc. You are also being asked to consent to have CHOICES, Intake and Records staff to re-release the information included in your Request for Services Packet to the ICM or ACT teams that will be assigned to provide you with services.

PURPOSE OR NEED FOR INFORMATION:

This information is being requested for the purpose of eligibility review and initial screening consultation:
(Describe the documents to be released by your agency to CHOICES, Inc)

AUTHORIZATION STATEMENT

It is understood that the psychosocial, psychiatric and other health related evaluations provided by my referral source,

Name of the Agency:

will be used by CHOICES, Inc. to evaluate me for possible referral to Intensive Case Management (ICM) or Assertive Community Treatment (ACT). If deemed eligible, I will be referred for the appropriate level of service, the information attached to this referral packet will be provided to the respective ICM or ACT provider, and I will be enrolled in their program.

A. I authorize CHOICES, Inc to review the application, psychosocial and psychiatric information ("Confidential Information") provided by my referral source, and if I am determined to be eligible, I authorize CHOICES, Inc Intake Coordinator to make recommendations for an appropriate program for my possible enrollment. If I am eligible, I also authorize CHOICES, Inc. use and disclose my Confidential Information to the Assigned ICM/ACT Program.

B. I understand that:

a. Only the Confidential Information described above may be used and/or disclosed as a result of this authorization.
b. My Confidential Information cannot legally be disclosed without my permission.
c. If my Confidential Information is disclosed to someone who is not required to comply with privacy laws, rules, or regulations, then it may be re-disclosed and would no longer be protected.
d. I have the right to revoke (take back) this authorization at any time, by writing to CHOICES, Inc. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my Confidential Information have already taken action because of my earlier authorization.
e. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from ICM or ACT program, nor will it affect my eligibility for benefits.
I have a right to inspect and copy my own Confidential Information and ensure that it is used and/or disclosed in accordance with the requirements of the applicable privacy laws, such as HIPAA

CLIENT SIGNATURE:

I have been given the opportunity to ask questions if I do not understand any of the information on this form. I certify that I authorize the use of my Confidential Information (including my medical and mental health information) as set forth in this document.

Client Name	*Signature*	*Today's Date*

Universal Referral Form

To be completed by a referring provider **(Required for all ACT program applicants)**

All referrals will be reviewed using eligibility criteria for ICM and ACT programs determined by the State of Alaska.
Priority for services will be given to persons who have the most serious mental illness and the most intensive need for services at the time of an opening. **Please note that housing services or subsidies are not available as a stand-alone service in any of CHOICES, Inc program**.

PERSONAL INFORMATION

1. First name ***2. Last Name*** ***3. M.I.*** ***4. Today's Date***

5. Any Accessibility Concerns? ***6. Date of Birth*** ***7. Age*** ***8. Social Security Number***

9. Gender

- ☐ Male ☐ Female
- ☐ Trans-Male ☐ Trans-Female
- ☐ Other ☐ Gender-Fluid

10. Psychosocial and Environmental Problems

- ☐ Primary Support ☐ Occupational ☐ Access to health care services
- ☐ Social Environment ☐ Housing ☐ Legal/Criminal
- ☐ Educational Problems ☐ Economic ☐ Other

11. Current Address *Apartment* *City* *State* *Zip*

12. Best Phone Number for the Client

May we leave a message? ☐ YES ☐ NO
Best time to contact: ☐ AM ☐ Afternoon ☐ PM ☐ Any time

13. Email Address

Please be aware that email might not be confidential.
Would the client like to receive updates and appointment reminders using your email address?

14. ***Health Insurance Coverage?*** ☐ YES ☐ NO 15. ***Insurance Agency:***

16. ***Policy Effective Date*** 17. ***Group ID Number*** 18. ***Member ID#***

CLINICAL INFORMATION

19. ***Is Person Interested in Case Management?*** ☐ YES ☐ NO

20. ***Provide Specific Reason(s) for Referral:***

21. ***Current Problems, Barriers, Challenges, OR Problems When Person is Not Stable:***

22. ***Is the client in custody?*** ☐ YES ☐ NO *If **YES**, what is their expected release date:*

BEHAVIORAL AND MENTAL HEALTH HISTORY

23. ***Please, report all conditions that the client have been assessed for and formally diagnosed by a mental health professional***.
[Attach any supporting documentation with this packet]

	CURRENT	PAST		CURRENT	PAST
Neurodevelopmental Disorders	☐	☐	Obsessive-Compulsive Disorders	☐	☐
Schizophrenia Spectrum	☐	☐	Trauma and Stress-Related Disorders	☐	☐
Other Psychotic Disorders	☐	☐	Dissociative Disorders	☐	☐
Bipolar and Related Disorders	☐	☐	Somatic and Related Disorders	☐	☐
Depressive Disorders	☐	☐	Feeding and Eating Disorders	☐	☐
Anxiety Disorders	☐	☐	Elimination Disorders	☐	☐
Sleep-Wake Disorders	☐	☐	Impulse Control and Conduct Disorders	☐	☐
Neurocognitive Disorders	☐	☐	Personality Disorders	☐	☐
Other Mental Disorders	☐	☐			

RISK AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

***Suicide Ideation**	☐	☐	**Suicide Attempts**	☐	☐
***Deliberate self-harm**	☐	☐	***Violent behavior/safety concerns**	☐	☐
***Legal involvement**	☐	☐	***Hx of intentional property damage**	☐	☐

24. ***History of Mental Health Treatment***

LEVEL OF TREATMENT	DATES (FROM - TO)	WHERE

25. ***Number of Psych Hospitalizations in the Last 2 Years:*** ______ *Reasons*: ______

SUBSTANCE USE DISORDER HISTORY

26. ***Does Person Have Problematic Use of Substances?*** ☐ YES ☐ NO *Date of Last Use*: ______

27. ***Substance(s) of Choice:*** ______

28. ***History of Drug/Alcohol or Co-Occurring Treatment:***

LEVEL OF TREATMENT	DATES (FROM - TO)	WHERE

OTHER INFORMATION

29. ***Current Impairments in Daily Functioning:***

30. ***Current Medical Issues, Chronic Health Conditions***

31. ***Current Medications*** (*please, indicate whether the client will have a sufficient supply for at least 30 days*)

CHOICES
Consumers Having Ownership in Creating Effective Services

Outreach Services Results

To be completed by the CHOICES, Inc. Intake Coordinator

CONTACT ATTEMPTS BEFORE ELIGIBILITY

OUTREACH ATTEMPTS:

Date	Method

******If Unable to Contact Stop Here****

IF CONTACT WAS ESTABLISHED

Appointment Type:	☐ Screening Consultation	☐ Intake Follow Up	☐ BHA/MHA
Date:			

OUTCOME

☐ **SCREENING CONSULTATION**

☐ Patient missed appointment
☐ Follow-up appointment for additional lead testing.
☐ Assistance needed scheduling appointment.
☐ No action taken; patient declined assistance
☐ Unable to locate patient; letter mailed to patient.
☐ Other

☐ **INTAKE FOLLOW UP**

☐ Patient missed appointment
☐ Follow-up appointment for additional lead testing.
☐ Assistance needed scheduling appointment.
☐ No action taken; patient declined assistance
☐ Unable to locate patient; letter mailed to patient.
☐ Other

☐ **BHA/MHA**

☐ Patient missed appointment
☐ Follow-up appointment for additional lead testing.
☐ Assistance needed scheduling appointment.
☐ No action taken; patient declined assistance
☐ Unable to locate patient; letter mailed to patient.
☐ Other

Care Coordination/Request for Services Information

Read this information before referring your clients for services at our agency

ABOUT THIS FORM

CHOICES, Inc has developed a single intake process for our major programs, including Assertive Community Treatment (ACT), Intensive Case Management (ICM), and Peer Support programs. Please use provided instruction to ensure accurate completion of this comprehensive form.

Care providers (*e.g., primary care, behavioral, and mental health, and social service providers*) must use this packet to refer their clients to CHOICES.

Applicants do not require a referral for ICM Program or Peer Support Services.
However, **all Assertive Community Treatment (ACT) program applicants must have a referral completed by a healthcare professional**.

Because of limited resources, providing help to the most vulnerable members of our community can be challenging. Coordination of services can be frustrating for individuals who may be struggling to manage their life as a result of their behavioral, mental health, or physical disability. Therefore, the supports and services you introduce may make a significant impact on improving the quality of life of this individual. We wish to be of help to you and your clients in making a proper transition to the next level of care.

Therefore, we must be sure that you and your client are aware of the specifics of the services we provide as well as the type of population we serve. We often meet with the clients who are under the impression that CHOICES is the agency that can provide immediate access to housing, food, and transportation. This is not our purpose.

BEFORE INITIATING A REFERRAL, PLEASE CONSIDER THESE TIPS:

1. Please refer to the **Prescreening Protocol** on **page 3** before completing a full application. If your predetermination review indicates this person is appropriate for referral for services, please complete the form. CHOICES, Inc. Intake Coordinator will make every effort to review requests promptly. We will inform you whether we can be of service to your client, and when we can begin the enrollment process.
2. It remains the responsibility of the referral source to maintain contact with the client until the directing clinicians have made the final decision about the client's eligibility for services.
3. Providing consistent, accurate, and realistic information is vital in helping your client to have clear expectations about services, especially when the circumstances may be stressful. To avoid any confusion about our services, consider the following:
    - ✓ **We cannot provide clients with immediate access to housing**
    - ✓ **We are NOT an "emergency shelter" and we do not enroll clients on the "same day" of inquiry.**
    - ✓ **We do not service individuals whose only unmet need is subsidized housing.**
4. If the individual/family mentions an interest in future placement (*for clients currently admitted to a long-term inpatient treatment),* and the individual's self-care needs are related to his/her severe and persistent mental health illness, you can discuss adding the individual's name to the Waiting List for future planning.
5. Caregivers who are frustrated with their loved one's life choices will sometimes look for a restrictive environment in hopes of reducing the behavior. Sometimes, when alternate placement is requested, the individual's mental health needs do not require a 24-hour or inpatient admission or plan of care. While CHOICES, Inc. can probably be of help to these people, we won't be able to provide immediate housing. Please consider a housing voucher with supports or a Residential Healthcare Facility. Again, we **do not** offer instant access to housing.
6. Intake Coordinator at CHOICES, Inc will review every referral for completion, which includes prescreening protocol. Sometimes we require additional information before we can begin the process. The client is more than welcome to schedule their initial screening consultation, but it is not going to result in an immediate enrollment. Please respond promptly to all collateral requests to prevent any delays.
7. Once you submit this application, you may consider continuing to provide supports and services to the client. We also encourage you to maintain contact with the client and us for updates during the process, which will take time. Our new intake process is much quicker than it used to be, but it still takes time.
8. ***Call 911 for a life-threatening emergency**, including Delirium Tremens (DTs) and other acute withdrawal symptoms, threats of suicide and/or harm to others.
    - ✓ We must ensure the safety of the person, and others, and where possibl, address withdrawal symptoms and to alleviate acute distress of the individual before attempting to engage them in outpatient counseling and case management services.

PLEASE NOTE: Submission of this application does not guarantee placement in program.

REFERRALS CAN BE <u>FAXED</u> TO (907) – 333 – 4383 OR <u>MAILED</u> TO 1231 GAMBELL STREET, SUITE 300, ANCHORAGE, AK 99501.

- ✓ Missing or inaccurate information may slow the assessment process.
- ✓ Please have the client read and sign Authorization to Re-Release Information section of the referral packet (page 4) and note that consent **must** be provided in order to process an application
- ✓ The confidentiality of the information you provide will be respected in adherence with the Health Insurance Portability and Accountability Act (HIPAA) and related Privacy Rules.
- ✓ Services provided by CHOICES Inc. programs are **voluntary**.

FREQUENTLY ASKED QUESTIONS (FAQS) FOR REFERRAL PROCESS

WHY DO WE NEED TO USE THIS FORM?

To improve client care and communication between referring providers and specialists; this form will help expedite the processing and accuracy of your referral. Please fill out the form carefully and completely, any missing information will result in the form being returned back to your office for clarification which may cause a delay in client care.

WHAT IF WE HAVE OUR OWN FORM?

We prefer you use our form however, if you have all the required information we will accept and enter your form. Please ensure that all required information is included on your form since any missing information will result in the form being returned back to your office to be fixed which may cause a delay in client care.

WHAT SERVICES DON'T FOLLOW THIS PROCES?

Project for Assistance in Transitioning from Homelessness (PATH) Program is our homeless outreach program funded by SAMHSA. This is the only program of CHOICES that does not follow this referral process.

WHY HAVEN'T YOU CONTACTED MY CLIENT?

CHOICES will not contact your client after receiving the form from you. We will process the request and notify the referring providers of the status of the referral. The referring provider is expected to contact the client with the referral information. You or the client may contact us to schedule the screening consultation after the referring provider has received a referral status update.
Please direct questions regarding a referral to Intake Coordinator at (907) – 302 – 1925

WHAT IF A MEMBER NEEDS RESIDENTIAL OR INPATIENT TREATMENT SERVICES?

We are able to make appropriate referrals to residential and/or inpatient treatment programs if the client requires a higher level of care, but so can you! If your client is experiencing a self-defined behavioral health crisis that prevents them from maintaining a healthy life in the community, such as severe emotional distress, depression, anxiety, psychosis, and suicidal ideations, in addition to experiencing acute withdrawal symptoms, you may really consider referring your client to Crisis Residential Program. We will be here for the clients, waiting for them when they are ready to transition to the outpatient level of care.

- ✓ **Inpatient involves being admitted to a hospital for acute psychiatric care**.
  Patients admitted to inpatient care are often at immediate risk of harming themselves or others.
  Examples: Alaska Psychiatric Institute (API) and Providence Crisis Recovery Center (CRC)
- ✓ **Residential treatment is often a step-down in intensity from inpatient services.**
  This is often a recommended course of discharge as once the client is stabilized during inpatient
  Clients step down to residential as a gradual release to home.
  Examples: Dena A Coy (*Southcentral Foundation*); Ernie Turner Center (*CITC*); Genesis Recovery, Inc.
- ✓ **Immediately upon being discharged from residential treatment, patients begin outpatient treatment while living at home so they can maintain the progress they've made with their mental health stability. This is where CHOICES, Inc may be of assistance to the client.**
  Outpatient programs are treatment programs used to address mental health disorders with or without co-occurring disorders and dependencies that do not require detoxification or round-the-clock supervision. These programs are designed to establish support mechanisms, help with symptom and relapse management, and provide coping strategies.
  Depending on the program, clients either visit the facility few times per week for individual or group counseling and case management (ICM); or being assisted by our providers in the comfort of their (clients') homes (ACT).

WHAT IS THE TURN-AROUND TIME TO APPROVE A REFERRAL REQUEST?

Via Fax – After we have received your referral, it may take up to 72 hours for us to review the application and to determine whether we can proceed with the enrollment; Care Providers may receive a fax-back if information is invalid or additional documents are necessary.
Via Mail - After we have received your referral, it may take up to 1-2 weeks for us to process the application; Care Providers may receive a fax-back if information is invalid or additional documents are necessary.
You or the clients may call us to get an update or to schedule a screening consultation after you have submitted a referral

DO I HAVE TO SUBMIT A REFERRAL EVERY TIME A CLIENT HAS FAILED TO SHOW UP FOR THEIR APPOINTMENTS?

Once a referral has been submitted, approved, and the client has been actively engaged in the enrollment process and successfully admitted to any of our programs, you do not need to submit another referral unless the client was discharged or terminated from services. Referral is valid for one (1) calendar year from the date of the Care Provider's submission; if after submission and approval of request for services we are not able to contact or locate the client (*we will make several attempts, including engaging our outreach team in locating the client*), we ask that you resubmit this form.

WHY ARE YOU MAKING THESE CHANGES?

Both the ease and the speed of the referral process are major concerns for clients that we serve. In fact, clients report greatest level of distrust, lack of confidence, and dissatisfaction with the typical process of referral where their initial care provider is not informing the client of the process and how long is the waiting time. Some clients end up seeking care elsewhere (e.g., emergency departments and urgent care clinics), and become "no-shows" for the eventual referral appointment.
We are attempting to standardize this process to ensure timely access to care for all clients seeking services.