CATHOLIC CHARITIES
ADULT MENTAL HEALTH AND RESIDENTIAL PROGRAMS
CENTRAL REFERRAL FORM

SEND TO: Catholic Charities
Central Referral Office
290 Front Street
Binghamton, New York 13905

Phone: (607) 723-9991
Fax: (607) 773-7891

Catholic Charities offers a wide range of Mental Health Services and Residential Services for adults with a mental health diagnosis requiring assistance to live successfully in the community. Use this referral form to refer an individual to one or more services.

This referral form and the consent for release of information will begin the initial screening process for all services requested on the form. Once received, referrals will be routed to all services checked.

- Acceptance into any Catholic Charities Adult Mental Health and Residential Programs will not be contingent upon participation in other Catholic Charities Services.
- Requesting a program does not assure acceptance in that program.

Incomplete referrals may not be routed until all information is received and may be returned to the referral source for completion for such items as an incorrect or missing release of information or if a program request is absent.

- Please include as much detail as possible to assist with best serving the consumer.
- Certain services will require additional information and assessments. You will be notified if that is necessary.
- Specific questions regarding requested programs may be directed to the identified program at 723-9991, Residential Services at 723-1804, or Four Seasons Club at 773-1184.

A Short Introduction to Releases of Information (ROIs)

Which release do I need?

- Use the Single Entry Committee release if you are referring the client for Case Management or Residential services.
- Use the Catholic Charities release if you are referring the client to Four Seasons, or Transportation.

What do I need to fill in?

Complete one release with your organization's name and address in the white box next to the Single Entry Committee or Catholic Charities box. This authorizes your organization to disclose information regarding the client to Single Entry or Catholic Charities (depending on which release is used).

Complete a second release for the client's current mental health provider or any other facility where relevant client records may be obtained: enter the facility name and address in the white box next to the Single Entry Committee or Catholic Charities box. This authorizes Single Entry or Catholic Charities (depending on which release is used) to obtain information from the named facility.

Who signs?

The client must sign the document where indicated, print his/her name where indicated, and date it.

A person who witnessed the client signing the document must sign the document, and should include title and date. This should not be an immediate family member. A document that does not include a witness signature is not valid.

What to attach?

With a signed release of information naming your organization or facility, you may attach or enclose relevant records originating with your facility.

Your assistance in getting signed releases from the client allows us to request records and is greatly appreciated because it enables us to serve the client more quickly and efficiently.

Please check the Box(es) for Program(s) Requested.

√	Programs	Referral Packet Pages 1 – 3	Releases of Information		Psychiatric Assessment/ Evaluation	Form OMH 143a	Community Support Services Functional Assessment Worksheet	CSS Transportation Program Form
			Single Entry Case Management/ Residential Services	Catholic Charities				
☐	SPOE Case Management Services	X	X		X			
☐	ACT	X	X		X			
☐	Residential Services Certified Program	X	X		X			
☐	Supported Housing Independent Living Program	X	X		X			
☐	Four Seasons	X		X	X	X	X	
☐	CSS Transportation Program	X		X		X	X	X

Agency Name: _____ Referral date _____

Referring Person *(Print)*: _____ Title _____

Address: _____

Phone #: (____) _____ Ext _____

1. Consumer Information

Consumer Name: Last _____ First _____ MI _____

Current Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Phone #: (____) _____ Gender: ☐ Male ☐ Female DOB: _____

Social Security #: _____ Highest Level of Education Completed _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Veteran: ☐ No ☐ Yes

Emergency Contact Person: _____ Telephone #: (____) _____

Relationship to Person: _____

Ethnicity: ☐ White ☐ African-American/Black ☐ Asian/Asian American ☐ Native American ☐ Latino/Hispanic ☐ Pacific Islander ☐ Other; specify

2. Financial Status: *(Monthly)* ☐ SSI $_____ ☐ SSD $_____ ☐ VA $_____

☐ Public Assistance $_____ ☐ Other $_____

Medicare #: _____ Medicaid CIN#: _____

Private Ins.: _____

Managed Care Insurance Provider: ☐ Excellus ☐ Fidelis ☐ CDPHP ☐ United Healthcare ☐ Other _____

Rep-Payee Services Needed: ☐ Yes ☐ No ☐ Unknown

Current Rep-Payee: ☐ No ☐ Unknown ☐ Yes Name _____

CONSUMER NAME _____

3. *DSM-IV Diagnosis:* *(Code **and** Description required. Include **current psychiatric and chemical addiction diagnoses.**)*

	Code	Description
Axis I	___ . ___	_____
	___ . ___	_____
Axis II	___ . ___	_____
	___ . ___	_____
Axis III	___ . ___	_____
Axis IV	___ . ___	_____

AOT Candidate: ☐ Yes ☐ No Current AOT Client: ☐ Yes ☐ No

To be completed by **State Psychiatric Center** only: **SPC Long Stay** ☐ Yes ☐ No

4. *Health Care Providers:*

A. Primary Care Physician Name: _____

Address: _____ Telephone #: (____) _____

B. Outpatient Psychiatrist's Name: _____

Address: _____ Telephone #: (____) _____

C. Current Therapist Name: _____

Address: _____ Telephone #: (____) _____

D. Current Case/Care Management Services: ☐ Yes ☐ No

(If yes, list agency): _____

5. *Psychiatric Treatment (Include Forensic):*

A. Inpatient History: (include dates and facility names)

_____

_____

B. Outpatient History: (include dates and facility names)

_____

_____

6. *Chemical Dependence* History of Substance/Alcohol Abuse: ☐ Yes ☐ No ☐ Unknown

A. Inpatient History: (include dates and facility names)

_____

_____

B. Outpatient History: (include dates and facility names)

_____

_____

CONSUMER NAME _____

7. *Conditions that require special services?* ☐ Yes ☐ No

If yes, explain: _____

_____

8. *High Risk Alerts:* *(Check if history of the following)*

☐ Suicide /Attempts	☐ Assault	☐ Frequent Crisis Requiring Readmission
☐ Suicidal Threats	☐ Medical Issues	☐ Non-compliance with Medication
☐ Fire Setting	☐ Inappropriate Sexual Behavior	☐ Non-compliance with Appointments
☐ Violent	☐ Self-Injurious Behaviors	☐ Victim of Physical/Sexual Abuse
☐ History of Homelessness	☐ Currently Homeless	

☐ Other (**Specify**)_____

If checked, provide dates and a brief explanation:

_____

_____

9. *Criminal Justice System.* *(Check if current or past history of the following - Provide name of Probation/Parole Officer if current.)*

☐ Conviction of a Crime	☐ Probation, expires _____	☐ CPL Status, expires _____
☐ Charges Pending	☐ Parole, expires_____	☐ Order of Condition, expires _____
☐ Currently Incarcerated		☐ Order of Protection, expires _____

Provide details; please include dates if known: _____

_____

_____

10. *Cultural Issues* *(for example, Language, social interaction, dietary restrictions)*: _____

_____

_____

11. *Reason for Referral/Treatment Team Recommendations:*_____

_____

_____

12. *Consumer Statement/Expectations:* *What are you hoping to receive from these services? What do you need help with?*

_____

_____

_____

_____

This statement completed by: ☐ Consumer ☐ Family Member ☐ Advocate ☐ Other _____

☐ I participated in completing this form. ☐ Consumer did nct participate. ☐ Referral completed without consumer present.

_____	_____	_____
Consumer (Print)	Signature	Date
_____	_____	_____
Witness (Print)	Signature	Date

CONSENT FOR RELEASE OF INFORMATION
FOR SINGLE POINT OF ENTRY FOR CASE MANAGEMENT & RESIDENTIAL SERVICES
Sponsored By: Catholic Charities of Broome County
290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____F_____
I authorize an exchange of PHI between: **SINGLE ENTRY COMMITTEE** (Including Representatives from): Broome County Mental Health Dept. Services, Greater Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry Coordinator, Our Lady of Lourdes Memorial Hospital Inc., The Family & Children's Society, Mental Health Association of the Southern Tier, Inc., Monroe Plan for Medical Care, United Methodist Homes, Catholic Charities of Broome County	AND: (Name, address, title of person/organization/facility/program): Catholic Charities of Broome County 290 Front Street Binghamton NY 13905 **ALL REFERALS REQUIRE THIS CONSENT**

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____	Diagnosis	_____	Financial Status	_____	Psychiatric Assessment
_____	Treatment Plan	_____	Inpatient/Cutpatient History	_____	Psychosocial History & Assessment

Purpose or need for information:

☐ **By the individual or his/her personal representative to facilitate placement in Case Management and/or Residential Services; or**

☐ **Other (describe)** _____

Note: if the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Catholic Charities. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility of benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: ☐ When I am no longer Receiving Services from Single Point of Entry ☐ One Year from this Date; ☐ Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ☐ When acted upon; ☐ Other

I certify that I authorize the use of my health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ Signature of Consumer or Personal Representative

_____ Printed Name of Consumer

_____ Date

_____ Printed Name of Personal Representative

_____ Description of Authority of Personal Representative

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____ Signature of Witness

_____ Name/Title

_____ Date

Form: ROISE:Rev 06/2017

CONSENT FOR RELEASE OF INFORMATION
FOR SINGLE POINT OF ENTRY FOR CASE MANAGEMENT & RESIDENTIAL SERVICES
Sponsored By: Catholic Charities of Broome County
290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____F_____
I authorize an exchange of PHI between: **SINGLE ENTRY COMMITTEE** (Including Representatives from): Broome County Mental Health Dept. Services, Greater Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry Coordinator, Our Lady of Lourdes Memorial Hospital Inc., The Family & Children's Society, Mental Health Association of the Southern Tier, Inc., Monroe Plan for Medical Care, United Methodist Homes, Catholic Charities of Broome County	AND: (Name, address, title of person/organization/facility/program): **Enter contact information of referral source** **ALL REFERALS REQUIRE THIS CONSENT**

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____	Diagnosis	_____	Financial Status	_____	Psychiatric Assessment
_____	Treatment Plan	_____	Inpatient/Cutpatient History	_____	Psychosocial History & Assessment

Purpose or need for information:

☐ **By the individual or his/her personal representative to facilitate placement in Case Management and/or Residential Services; or**

☐ **Other (describe)** _____

Note: if the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Catholic Charities. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility of benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: ☐ When I am no longer Receiving Services from Single Point of Entry ☐ One Year from this Date; ☐ Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ☐ When acted upon; ☐ Other

I certify that I authorize the use of my health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____	_____	_____
Signature of Consumer or Personal Representative	Printed Name of Consumer	Date
_____	_____	
Printed Name of Personal Representative	Description of Authority of Personal Representative	

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____	_____	_____
Signature of Witness	Name/Title	Date

Form: ROISE:Rev 06/2017

CONSENT FOR RELEASE OF INFORMATION
FOR SINGLE POINT OF ENTRY FOR CASE MANAGEMENT & RESIDENTIAL SERVICES
Sponsored By: Catholic Charities of Broome County
290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____F_____
I authorize an exchange of PHI between: **SINGLE ENTRY COMMITTEE** (Including Representatives from): Broome County Mental Health Dept. Services, Greater Binghamton Health Center & Community Treatment & Recovery Center, Broome County Dept. of Social Services, United Health Services & New Horizons, Addictions Center of Broome County, Fairview Recovery Services Inc., NYS Office for People With Developmental Disabilities, Broome County Reentry Coordinator, Our Lady of Lourdes Memorial Hospital Inc., The Family & Children's Society, Mental Health Association of the Southern Tier, Inc., Monroe Plan for Medical Care, United Methodist Homes, Catholic Charities of Broome County	AND: (Name, address, title of person/organization/facility/program): **Enter contact information where psychiatric records can be obtained** **ALL REFERALS REQUIRE THIS CONSENT IF RECORDS ARE OBTAINED OUTSIDE OF THE REFERRAL SOURCE SITE**

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____	Diagnosis	_____	Financial Status	_____	Psychiatric Assessment
_____	Treatment Plan	_____	Inpatient/Outpatient History	_____	Psychosocial History & Assessment

Purpose or need for information:

☐ **By the individual or his/her personal representative to facilitate placement in Case Management and/or Residential Services; or**

☐ **Other (describe)** _____

Note: if the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Catholic Charities. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility of benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: ☐ When I am no longer Receiving Services from Single Point of Entry ☐ One Year from this Date; ☐ Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ☐ When acted upon; ☐ Other

I certify that I authorize the use of my health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ Signature of Consumer or Personal Representative

_____ Printed Name of Consumer

_____ Date

_____ Printed Name of Personal Representative

_____ Description of Authority of Personal Representative

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____ Signature of Witness

_____ Name/Title

_____ Date

Form: ROISE:Rev 06/2017

CONSENT FOR RELEASE OF INFORMATION
FOR CATHOLIC CHARITIES MENTAL HEALTH SERVICES
290 Front Street, Binghamton, New York 13905

This authorization must be completed by the consumer or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulation that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.	CONSUMER NAME: _____ CONSUMER'S DATE OF BIRTH: _____ SEX: M_____ F_____
I authorize an exchange of PHI between: **Catholic Charities Mental Health Services** **290 Front Street** **Binghamton, New York 13905**	AND: (Name, address, title of person/organization/facility/program): Enter contact information where psychiatric records can be obtained **(Complete ONLY for Four seasons referral and or Transportation)**

Description of information to be used/disclosed is as follows: Include dates where appropriate.

_____ Medication/Past & Present	_____ Medical, Lab & Physical Exam Information
_____ Psychological and Neurological Tests	_____ Functional Assessment & Employment History
_____ Psychosocial History & Assessment	_____ Referral Packet
_____ Discharge Summary/Treatment Plans	_____ Psychiatric Assessment
_____ Other (Progress Notes)	_____ Physicians Authorization For Restorative Services

Purpose or need for information:

❑ **By the individual or his/her personal representative to facilitate admission and appropriate psychiatric rehabilitation treatment planning; or**

❑ **Other (describe)** _____

Note: if the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I uncerstand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or redisclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected;
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- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire: When I am no longer Receiving Services from Catholic Charities One Year from this Date; Other	I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire: ❑ When acted upon; ❑ Other

I certify that I authorize the use of my health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

_____ Signature of Consumer or Personal Representative	_____ Printed Name of Consumer	_____ Date
_____ Printed Name of Personal Representative	_____ Description of Authority of Personal Representative	_____ Date

I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION.

_____ Signature of Witness	_____ Name/Title	_____ Date

K:ROICC06/2017