Office of Substance Abuse and Mental Health Services
PNMI REFERRAL/APPLICATION

Date:_____

Consumer Name:_____**Gender: □ Male □ Female □Transgender**

Current Address_____

Marital Status: □ Single □ Married □ Domestic Partner □ Divorced □ Widowed

D.O.B.:_____ **Social Security Number**_____

Income Source_____**Amount**_____**MaineCare Number:**_____

Maine Care Status: □ Categorical □ Non- Categorical □ Applied/Pending_____**(date applied)**
□ Spend Down_____**(amount)**_____**(deductible dates) □ Other Insurance**

Housing Subsidy (BRAP, Shelter + Care, Section 8)?_____**No/ Applied-Pending**_____**(Date)**

Referral Source:_____**Phone:**_____**Contact Person:** _____

Referent E Mail Address: _____

Consumer Area Housing Preference (check all that apply):

☐ **Aroostook** ☐ **Hancock** ☐ **Washington** ☐ **Penobscot** ☐ **Piscataquis** ☐ **Kennebec**
☐ **Somerset** ☐ **Knox** ☐ **Lincoln** ☐ **Sagadahoc** ☐ **Waldo** ☐ **Androscoggin** ☐ **Franklin**
☐ **Oxford** ☐ **Cumberland** ☐ **York**

Referral is for (Primary PNMI program choice):_____**(Secondary Choice)** _____

Reason for referral:

_____
_____
_____
_____
_____

Does the consumer have any special considerations/needs/accommodations to be considered for this referral?
□ Yes □ No
If yes, please note: □ Awake night staff □1:1 □ handicap accessible □ medical monitoring
□ other _____
_____
_____

Please note any prior living arrangements and/or periods of homelessness. What worked? What didn't?

_____
_____
_____

Does the consumer require ADL assistance: □ Yes □ No
If yes, explain: _____

_____

_____

Current Resources/Supports:
Does the consumer have a guardian? □ No □ Public □ Private □ Under Study
Is the guardianship □ Full □ Limited **Explain:** _____
Guardian contact first and last name: _____
Guardian Telephone Number: _____
Does the consumer want the services being requested? □ Yes □ No
If no, please explain: _____

_____

Does the consumer have a Rep Payee? □ Yes □ No
If yes, contact first and last name: _____
Rep Payee Telephone Number: _____

Does the consumer have a case manager? □ Yes □ No
If yes, case manager first and last name: _____
Case Management Agency and Telephone Number: _____

Does the consumer have a Primary Care Physician? □ Yes □ No
If yes, name of Primary Care Physician: _____
PCP Telephone Number _____

Family and/or Other Supports (any other pertinent psychosocial information):

_____

_____

_____

What has family involvement been with consumer?
□Phone □Visits □Treatment Sessions □ Other □Consumer Refuses □Other

Is there a current contact person? (please list name and telephone number): _____

_____

LEGAL ISSUES:
Does the consumer have any current legal issues/charges? □ Yes □ No
If yes, explain: _____

_____

Does the consumer have any past legal issues? □Yes □ No
If yes, explain: _____

_____

Is the consumer involved with pre-trial? □ Yes □ No
Does the consumer have a probation officer? □ Yes □ No
If yes, probation officer name: _____ **Telephone Number:** _____
Does the consumer have conditions of release? □ Yes □ No
If yes, explain? _____

_____

DIAGNOSIS

Primary Diagnosis: _____
Secondary Diagnosis: _____
Other Diagnoses: _____

Current LOCUS Score: _____
Date Diagnosed: _____ **Name and License Level of Diagnostician:** _____
CURRENT SYMPTOMS: _____

_____
_____
_____

Suicidal? Y□ N□ **If Yes,** □Ideation □Plan □Means □Intent □Attempt □Hx of Attempts

Homicidal? Y□ N□ **If Yes,** □Ideation □Plan □Means □Intent □Attempt □Hx of Attempts

Psychosis? Y□ N□ **If Yes,** □Delusional □Paranoid □Unable to Care for Self □Other

Hallucinations? Y□ N□ **If Yes,** □Auditory □Visual □Tactile □Olfactory

Depressed? Y□ N□ **If Yes, check signs/symptoms:** □Eating □Sleeping □Energy □Isolation
□Weight Gain □Other somatic or vegetative symptoms

Are there other areas of risk not previously noted, such as elopement, self-injurious or assaultive behavior that would be helpful to know? _____

_____
_____
_____

Does the Consumer have any current Substance Abuse or Dependence Issues? □ Yes □ No
If yes, please check all that apply:
□ Alcohol □ Cocaine/Crack □ Marijuana □ Ecstasy □ Over the Counter meds
□ Sedatives/Hypnotics □Opiates/Pain Killers (Heroin, Methadone, Oxycontin, Oxycodone, etc.)
□ Tobacco □ Caffeine □ Amphetamine/Methamphetamine □ Benzodiazepines
□ Other Street Drugs □Other: _____

Dates of onset? _____ **Current Amounts?** _____
Dates of last use/remission? _____
Other Pertinent Substance Use or Dependence History: _____

_____
_____

CURRENT AND PRIOR TREATMENT (Mental Health and/or Co-Occurring):
Inpatient (please note name of hospital and dates):

_____
_____
_____

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Outpatient (please note agency name, provider names, and dates):

_____
_____
_____

Other: _____

MEDICAL HX AND UPDATES (include relevant lab work and any known allergies):

_____
_____
_____

Has this person ever had a brain injury: □ Yes □ No
If yes, please explain: _____
_____

Does this person have a history of intellectual disability or cognitive challenges? □ Yes □ No

_____

Medications (both psychiatric and medical/please note current / any recent changes/who prescribes the medications):

_____
_____
_____

Baseline behavior? How do you know when the client is doing well? Hobbies? Interests? _____
_____
_____
_____

Education History and Current Status: _____
_____

Vocational History and Current Status: _____
_____
_____

Please list any recent and pertinent assessments that have been done within the past three to six months such as Occupational Therapy, Neuropsychological, Psychosexual, or Psychiatric, or Psychological, including dates and assessor contact information or other relevant information.

_____
_____
_____

To keep this application ACTIVE, please call (as provider or as client) to check in every 90 days. This referral will be considered INACTIVE if no contact (email, call or fax) is made by provider or client with SAMHS to follow up on this application.

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Below is the quoted MaineCare rule for Medical Necessity:

10-144 Chapter 101 Department of Health and Human Services MAINECARE BENEFITS MANUAL Chapter II Section 97 PRIVATE NON-MEDICAL INSTITUTION SERVICES ESTABLISHED

97.02-2 **Medical Necessity** Services in PNMIs must be medically necessary, as evidenced by meeting the medical eligibility criteria set forth in this section. A physician or primary care provider must also document in writing that this model of service is medically necessary for the member, and both the physician and the PNMI provider must keep this documentation in the member's file. For all PNMI services, this documentation must be completed as part of the prior authorization process conducted by the Department and/or its Authorized Agent.

Additional PNMI Provider Requirements:

Accept all Referrals from the Department, in writing to SAMHS staff, within three (3) business days of receipt of Referral.

Note: Section 277 of the Bates v. DHHS Consent Decree (Consent Decree) does not allow for the denial of a Referral without the Department's approval. Any such denial, which has not been approved, is a violation of this Agreement and may result in termination of this Agreement.

Contact the individual being Referred and/or the legal guardian within seven (7) business days of receipt of this Referral. Confirm in writing to SAMHS Residential Team, once contact with individual and/or legal guardian has been made. Admit all individuals to the PNMI within thirty (30) calendar days of the receipt of Referral.

CONSENT DECREE COMPLIANCE REFERRAL FORM:

Client Referred:
Primary Service Provider Agency Name (Referred to):
Name of Residential Treatment Facility, If Applicable:
Address of Discharge Location:
Contact Name:
Contact E-mail:
Contact Phone #:

☐ Accepted Start Date:
☐ Accepted with requested accommodation(s) Start Date:
Accommodation(s) requested:

☐ Declined or cannot accept Decline Date:
Reason:
☐ Hospital determined patient not ready
☐ Patient refused
☐ Facility is already 100% occupied (no vacancies)
☐ Other: _____

PLEASE FAX THIS PROMPTLY TO:

287-7056 SAMHS

Which DHHS office(s) should help you? Please check.

□Office of MaineCare Services	X Substance Abuse and Mental Health Services
❒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:

Whose information is being released? Please print clearly.

Individual's Name		Date of Birth	Social Security #
Home Address	Town/City	State	Zip Code
Telephone ( ) -	Email address @		

What information should DHHS release? Please check all that apply.

General permission: **X All** health information from the DHHS office(s) checked above ❒ Claims or encounter data (information about visits to health care providers) ❒ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ❒ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015- 2017") _____ ❒ Other:_____	**Special permission**: D**rug/Alcohol Referral or Services** ❒ Include **all** drug/alcohol information in the release ❒ Include only the **specific** drug/alcohol records checked: ❒ Diagnosis and treatment ❒ Clinical notes and discharge summaries ❒ Drug/Alcohol history or summary ❒ Payment or claims information ❒ Living situation and social supports ❒ Medication, dosages or supplies ❒ Lab results ❒ Other: _____
Special permission: Mental/Behavioral Health Services ❒ Include this information in the release ❒ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ❒ Include this information in the release **Please note**: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

Are you asking DHHS to send your information by EMAIL? ❒ Yes. ❒ No

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email**. INITIAL HERE** _____
Where should DHHS send your information by email? Please print the email address clearly:

What is the purpose of the release? Please check or write a response.

❒ To coordinate or manage my care ❒ For a legal matter, including to provide testimony
❒ A personal request ❒ To see if I qualify for benefits or insurance ❒ Other _____

Please check and print clearly below: ❒ Send my information to ❒ Get my information from:

Name	Name
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone Fax No.	Phone Fax No.

I understand and agree that:

- "Information" may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

Date:_____ **Signature**_____

Personal Representative's authority to sign: _____