

PEER SERVICES REFERRAL FORM

Date: _____

Please Fax Referral and Signed Consent to: (607) 756-5999

Participant Information:

Name: _____ Date of Birth: _____ SS#: _____

Best Phone: _____ Email: _____

Address: _____

Emergency Contact Name: _____ Emergency Contact Phone/Email: _____

Medical Insurance: Medicaid #: _____ Other Medical Insurance: _____

Provider Referral Information:

Referral Agency: _____ Provider Name: _____

Provider Phone: _____ Provider Email: _____

Provider Address: _____

Medical/Health Status:

Health Area	Concerns/Diagnosis/Treatment	Providers (past/present)	Appointments
Physical			
Mental			
Substance Use			
Other			

How Can We Help You Today? (please check those that apply)

Housing Financial Support Health Care Social Support

Mental Health Counseling/Treatment Substance Use Counseling/Treatment

Education/Vocational/Employment Other: _____

Would You Be Interested in Learning More About Peer Services? (please check those that apply)

Peer Support (peer mentoring, bridging to services, empowerment, etc.) Advocacy

Life Skills (budgeting, organization, communication, etc.) Peer Socialization (social supports)

Participant Name: _____

Date: _____

Tell us More About Yourself (please fill in all areas that apply)

Financial:

Have you Been to DSS? Yes No If yes, County Caseworker Name: _____

Public Assistance: TANF SNAP HEAP

Other Current or Past Income (SSI/Disability/Veterans): _____

Education/Employment:

Education: HS Diploma/GED College Vocational

Employment Status: Employed Unemployed Self-employed

Current Living Needs:

Are You Homeless _____ Do You Have a DSS Housing Voucher? _____ Where are You Housed? _____

Live Alone Lives with Family or Friends

Other Residential Program _____

Family/Social/Community Supports:

Family or Friends _____ Counseling/Treatment _____ Agency Services _____

Health Care Provider _____ Faith or Support Groups _____ Other _____

Do You Have Any Concerns or at Risk? (Please check all that apply)

Suicide Attempts/Ideation Self Injury/Harm/Neglect

Isolation Drug/alcohol misuse

Harm from others: Physical Emotional Financial Sexual

Violence Towards Others: Physical Sexual Family/friends Public/Property

Please fax referrals **with signed release of information**

Attention to: Julie Partigiani and Kathy Carstens

at (607) 756-5999

or secure email to Peer Services Program

jpartigiani@ccocc.org

For questions you may call (607) 423-7472



Client's Name (Last, First, M.I.)	Medicaid CIN:
Date of Birth	Program Name: <u>Peer Services</u>
Facility Name: <u>Catholic Charities of Cortland County</u>	

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization must be completed by the client or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

<input type="checkbox"/> Contact Information	<input type="checkbox"/> Current Medications	<input type="checkbox"/> Current Services	<input type="checkbox"/> Daily Living Skills	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Education	<input type="checkbox"/> Entitlements	<input type="checkbox"/> Emergency Contact Info.	<input type="checkbox"/> Functional Abilities	<input type="checkbox"/> Mental Health Status
<input type="checkbox"/> : _____				

Info can be disclosed:

Verbal

Written

Purpose or Need for Information:

1. This information is being requested:

by the individual or his/her personal representative; or

Other (please describe) _____ Catholic Charities of Cortland County

2. The purpose of the disclosure is (please describe)

<input type="checkbox"/> Assessment	<input type="checkbox"/> Bill Insurance	<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> Emergency Services
<input type="checkbox"/> Establish Entitlements	<input type="checkbox"/> Establish Services	<input type="checkbox"/> Housing	<input type="checkbox"/> Skill Development
<input type="checkbox"/> Treatment Coordination			
<input type="checkbox"/> OTHER: _____			

Exchange of Information between the parties below
(Include: Name, Address, Title of person/Organization/Facility/Program)

<p>Catholic Charities of Cortland County Peer Services Program 33-35 Central Avenue Cortland, New York 13045 Phone: (607) 756-5992 Fax: (607) 756-5999</p>	<p>Organization Name:</p> <p>Address:</p> <p>Phone:</p> <p>Fax:</p>
---	---

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain services from the Catholic Charities of Cortland County, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

Facility/Agency Name Catholic Charities of Cortland County	Client's Name (Last, First, M.I.)
<p>B. Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.</p> <p>My authorization will expire:</p> <p><input type="checkbox"/> When I am no longer receiving services from <u>Catholic Charities of Cortland County</u></p> <p><input type="checkbox"/> One year from this date</p> <p><input type="checkbox"/> Other: _____</p>	
<p>C. Client Signature: I certify that I authorize the use of my health information as set forth in this document.</p>	
Signature of Client or Personal Representative _____	Date _____
Client's Name (Printed) _____	
Personal Representative's Name (Printed) _____	
Description of Personal Representative's Authority to Act for the Client <i>(required if Personal Representative signs Authorization)</i>	
<p>D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was offered and/or provided to the client and/or the client's personal representative.</p> <p>WITNESSED BY: _____ <div style="text-align: center; margin-left: 150px;">Staff person's name and title</div></p> <p>Authorization Provided to: _____</p> <p>Date: _____</p>	
PART 2: Revocation of Authorization to Release Information	
<p>I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
Signature of Client or Personal Representative _____	Date _____
Client's Name (Printed) _____	
Personal Representative's Name (Printed) _____	
Description of Personal Representative's Authority to Act for the Client <i>(required if Personal Representative signs Revocation of Authorization)</i>	