**DPBHS Access Department**

# OUTPATIENT FUNDING REFERRAL - ADMISSION

**Required Referral Information**

****For children in crisis, call Mobile Response Stabilization Services (Child Crisis Hotline) at 1-800-969-4357****

This is a request for PBH to authorize you to provide **outpatient mental health and/or substance abuse treatment** to clients without mental health and/or substance abuse coverage.

***** Please note: Incomplete referrals cannot be processed and will be returned. Corrections must be received within 30 days or a new referral with current clinical information and signatures dated within the last 30 days must be re-submitted. Please allow up to 1 week for processing of a complete referral. *****

## Eligibility

- Clients eligible for PBH outpatient funding do not have **outpatient mental health and/or substance abuse treatment coverage**.
- Some examples: No insurance; Medicaid **without** a Managed Care Organization; exhaustion of 30 yearly Medicaid units; Private Insurance without mental health and/or substance abuse coverage.
- You/your agency must have an existing PBH contract or waiver prior to receiving authorization.
- We must receive requests for authorization prior to 90 days from the date the service occurred.

## Next Steps

- If approved, the authorization we send you will allow you to bill PBH for the indicated service for the specified period only.
- If the client continues to need outpatient treatment and remains without coverage, you must submit a **Reauthorization Request** to PBH prior to the original authorization's end date.

## Please Don't Forget (if applicable)

☐ **Legal guardians**: A court order indicating guardianship rights of the person who signs this form.

☐ **Exhaustion**: An official denial letter or Explanation of Benefits from the MCO

☐ **Private Insurance**: An official denial letter or Summary of Benefits and Coverage indicating client's plan lacks mental health and/or substance abuse coverage.

**DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES**
**DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES**
**Terry Center Pod 3, 10 Central Ave., New Castle, DE 19720**
**1-800-722-7710**

## DPBHS Access Department

# OUTPATIENT FUNDING REFERRAL - ADMISSION

**Please fill out this form as completely as possible and call if you need assistance.**

**Fax this form to (302) 622-4475 or mail it to the address above or email to: DSCYF_Intake_General@delaware.gov**

Admit Date (client's **first un-covered session)**:_____ Number of Sessions (from Admit Date): _____

### CHILD INFORMATION

Date:_____ Child's Name:_____

DOB: _____ Gender: ☐ M ☐ F Race:_____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ County:_____

School:_____Grade: _____ Education Type: ☐Regular ☐Special

### PARENT/GUARDIAN INFORMATION

Name: _____

Relationship to Child**: _____

Address: _____

City: _____ State: _____ Zip:_____

Best Phone Number:_____Other Phone: _____

** If this is not the parent, a guardianship court order must be provided.

### INSURANCE INFORMATION

Active Medicaid? ☐Y ☐N Member ID #: _____

If so, which Managed Care Organization: ☐ None ☐Highmark Health Options ☐ United Health Care

Have sessions/units been exhausted? ☐Y** ☐N

** You must include a denial letter or Explanation of Benefits (EOB) from the MCO indicating exhaustion.

### CLIENT'S DIAGNOSIS – INCLUDE DSM V CODES

[DSM V diagnosis and code.]

**REFERRAL AGENT**

Completed by:_____ Organization/Agency: _____

Relationship to Child:_____ Position: _____

Email: _____

Phone:_____ Fax: _____

**TREATMENT PLAN**

What is the client being treated for?

What are the treatment goals?

I understand that I am applying for DPBHS outpatient services. I attest that the information listed above is correct to the best of my knowledge. I consent to the sharing of information between DPBHS and the treatment provider for funding authorization, treatment planning, and monitoring.

_____ _____

Signature: Parent/Legal Guardian/Custodian (circle one) Date

_____ _____

Signature: Youth (if 14 years or older) Date

_____ _____

Signature: Therapist/Clinician Date

# DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

**Child's Name:** _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

**Relationship with the child**: _____

**Instructions** *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

| | | During the past **TWO (2) WEEKS,** how much (or how often) has your child… | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|---|
| I. | 1. | Complained of stomachaches, headaches, or other aches and pains? | 0 | 1 | 2 | 3 | 4 | |
| | 2. | Said he/she was worried about his/her health or about getting sick? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | Had less fun doing things than he/she used to? | 0 | 1 | 2 | 3 | 4 | |
| | 6. | Seemed sad or depressed for several hours? | 0 | 1 | 2 | 3 | 4 | |
| V. & VI. | 7. | Seemed more irritated or easily annoyed than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 8. | Seemed angry or lost his/her temper? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | Started lots more projects than usual or did more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 10. | Slept less than usual for him/her, but still had lots of energy? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | Said he/she felt nervous, anxious, or scared? | 0 | 1 | 2 | 3 | 4 | |
| | 12. | Not been able to stop worrying? | 0 | 1 | 2 | 3 | 4 | |
| | 13. | Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her? | 0 | 1 | 2 | 3 | 4 | |
| | 15. | Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else? | 0 | 1 | 2 | 3 | 4 | |
| | 17. | Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | 0 | 1 | 2 | 3 | 4 | |
| | 18. | Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned? | 0 | 1 | 2 | 3 | 4 | |
| | 19. | Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening? | 0 | 1 | 2 | 3 | 4 | |
| | | In the past **TWO (2) WEEKS,** has your child … | | | | | | |
| XI. | 20. | Had an alcoholic beverage (beer, wine, liquor, etc.)? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 21. | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 22. | Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 23. | Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| XII. | 24. | In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 25. | Has he/she EVER tried to kill himself/herself? | Yes | | No | Don't Know | | |

# CONSENT FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION
# DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES

Client Name:_____DOB:_____

I, (Parent/Guardian/Custodian/DFS)_____hereby authorize the Division of Prevention and Behavioral Health Services (DPBHS) to Release Verbal/Written Information to and to receive verbal and written information from:

Agency name or school:_____
Name of contact person at agency/school (if known):

**Verbal and written information to be released by DPBHS: (Check all items that apply.)**

- ☐ Admission / Discharge Summaries (DPBHS services for past 2 years)
- ☐ Service Admission Form (includes Demographics, CSM Service Plan, DPBHS Treatment History, Medication History, Risk Factors)
- ☐ DPBHS Psychosocial Evaluation ☐ DPBHS Psychological Evaluation ☐ DPBHS Psychiatric Evaluation
- ☐ Educational Records ☐ Treatment Progress/Summary
- ☐ Most recent physical exam (not to include pregnancy, STD, HIV information)
- ☐ Other: _____

**The purpose of this information disclosure by DPBHS is to: (Check all items that apply.)**

- ☐ Make a referral/provide treatment by the clinical treatment organization or person listed above
- ☐ Assist in the completion of PBHS Evaluation(s)
- ☐ Provide clinical information to organization or person named above

**Verbal and written information to be released to DPBHS: (Check all items that apply.)**

- ☐ Initial Evaluation ☐ Comprehensive Treatment Plan ☐ Discharge Summary
- ☐ Treatment Progress Summary ☐ Physical Examination ☐ Speech and Language Evaluation
- ☐ Neurological Evaluation ☐ Medication History ☐ Psychiatric Evaluation
- ☐ Most recent educational records including educational testing and school psychological, IEP/IPRD documents, school attendance and behavioral/disciplinary records
- ☐ Other _____

**The purpose of this information disclosure by the agency/school named above is to: (Check all items that apply.)**

- ☐ Enable PBHS to Plan, Monitor, Authorize Payment, Coordinate Care with Treatment Provider
- ☐ Enable PBHS to use the educational material in planning treatment
- ☐ Enable PBHS to collaborate with the school in planning and providing services
- ☐ Assist in the completion of PBHS Evaluation(s)

I understand that this form can not be used to release information about drug and alcohol treatment, pregnancy, HIV status, and sexually transmitted diseases.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Director of Quality Improvement in the Division of Prevention of Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information used or disclosed as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Director of Quality Improvement, Division of Prevention and Behavioral Health Services.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R. pts. 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it, therefore the privacy regulations may no longer protect it.

**This authorization is valid for one year from the signature date unless revoked.**

_____ _____
Parent, Guardian, Custodian, DFS Signature (Circle one) Print Name/Date

_____ _____
DSCYF Representative Signature Print Name/Date

**DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES**
**DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES**
**1825 Faulkland Road, Wilmington, DE 19805**

## CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I,_____, authorize
(Print name of youth)

Please check appropriate box:

- ☐ Division of Family Services (DFS)
- ☐ Division of Youth Rehabilitation (YRS)
- ☐ Parent / Guardian
- ☐ Family Court
- ☐ Superior Court
- ☐ Department of Education (DOE)
- ☐ Multi Disciplinary Team (MDT)
- ☐ Deputy Attorney General's Office (DAG)
- ☐ Public Defender (PD) / Private Attorney (PA)
- ☐ Other (Please specify): _____

☐ To disclose ☐ To receive from the Division of Prevention and Behavioral Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Prevention and Behavioral Health Services evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

**THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM DATE OF SIGNATURE**

| _____ | _____ | _____ |
|---|---|---|
| Signature of Youth<br>(mandatory for 14 years and older) | Print Name of Youth | Date |
| _____ | _____ | _____ |
| Signature of Parent or Guardian<br>(mandatory if client under 14 years old) | Print Name of Parent or Guardian | Date |

## PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.