PRESENCE REFERRAL PACKET

Who We Serve:

✓ Individuals

- of all ages,
- determined by the Office for People with Developmental Disabilities (OPWDD) to have a developmental disability and
- have Medicaid insurance.

Referral Process:

1. Please complete the referral form on pages 1-2 of this document
2. Read and complete the Permission to Use and Disclose Personal Health Information on page 2 of this document.
3. Read and complete the Permission for Treatment of Services to assign referral to a professional health provider on pages 3-4 of this document
4. Read and complete screening tools on pages 5-9 of this document as needed.
5. Submit completed packet and copies of eligibility documents (listed on page 2)

Email: info@presencedevelopmental.com **Fax #** 315-515-5194 **Mail:** 115 Fall St, Seneca Falls, NY 13148

Referral Information

Person Completing Form

Name: Title: Organization:

Email: Phone:

Person Needing Services

Name: Date of birth:

*Note: If the individual is under the age of 18, provide a legal guardian's name and date of birth for insurance verification.

Legal guardian Date of Birth:

Medicaid ID# **Additional Insurance Information:** Insurance Name:

Insurance ID#

Primary Subscriber (if not Individual referred):

Phone #: ☐By checking this box, you agree to receive text messages from Presence related to this referral and schedule. Msg + data rates may apply.

Best time of day to contact: Email:

Street Address, City & Zip:

Current living setting:

☐ Family/Relative Home

☐ Community Residence
☐ Individualized Residential Alternative
☐ Private Residence (on own)

Select & describe the reason(s) for referral:
☐ Social Work ☐ Behavioral Support Therapy
☐ Occupational Therapy ☐ Speech-Language Pathology ☐ Physical Therapy
Describe the reason for referral:

Preferred Service Location: ☐In-home ☐Community ☐office
Specify the primary language spoken if other than English:

Eligibility Documents:

- Insurance cards- front & back include primary subscriber information if different than the referred individual.
- Life plan.
- IEP (for school-aged referrals)
- Script for the PT, OT, and SLP evaluation
- The signed authorization (s) of consent to disclose PHI.

Permission to Use and Disclose Personal Health Information

The person whose information may be used or disclosed is:
Name:
Date of Birth:

- The information that may be disclosed includes your contact and insurance information as specified on page 1.
- This information may be disclosed to Presence Services.
- Use and disclosure of this information is permitted only as necessary for pre-enrolment evaluation and contact.
- This permission expires on **(date)**.
- I understand that this permission may be revoked.

I am the person whose records will be used or disclosed or that individual's representative.
(If personal representative, please enter the relationship).

I permit you to use and disclose my records as described in this document.

Printed Name of signer:
Signature:

Date:

☐By signing this Consent Form, you permit Presence to contact you or your representative.

PRESENCE REFERRAL PACKET

Permission for treatment/services

Freedom of Choice

I understand that the choice of providers is my responsibility and right as the individual or guardian. I understand further that I have the right to contact the providers prior to selection so that I may determine the best provider. I also understand that I may at any time choose another provider for this service by notifying my current provider.

Informed Consent

I understand that participation in treatment does not guarantee anticipated outcomes. I understand that there may be unintended results of treatment affecting the individual and other family/household members. I understand that providers are legally bound to report suspected abuse of the individual or of other family members. I also understand that the providers have a duty to warn any intended victim of a threat to harm.

Persons Participating in Home and Community-Based Services

I understand that I am permitted to include in the individual's treatment sessions any persons present in the home, school, or community at the time of service. This includes but is not limited to myself, parents, spouses, step-parents, paramours, siblings, children, extended family, household visitors, caregivers, playmates and classmates. I also understand that I have the right to dismiss anyone from participating in a session at any time and that I have the right to exclude anyone from the ongoing treatment process by written notice to the provider.

Telehealth Services

I understand that telehealth services may be recommended as part of treatment. I have received information on the limits and process of telehealth and consent to telehealth care services.

Privacy Practices

I understand that Presence Developmental Services and Presence Counseling Services adhere to the Health Insurance Portability Act and I agree to these practices. I agree that this information has been made available to me for review.

Responsibilities

I understand my responsibility is to: 1) provide accurate information and report any changes in individual wellbeing, 2) to keep all appointments and to give 24-hour notice of a need to reschedule, 3) to maintain the individual's insurance coverage and report any lapse in coverage to the service provider, 4) to contribute to a plan of treatment and to follow through with agreed upon interventions.

I understand that I am financially responsible for any services received. I agree to report on all primary and secondary insurance coverages. I agree to pay any co-pay, deductibles, and co-insurance agreed upon with my insurance company. I give permission to file insurance claims on services provided by any insurance company with which I or my child is enrolled. I give Presence Developmental Services and Presence Counseling Services permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Presence Developmental Services and Presence Counseling Services staff are also providing treatment.

Permission is hereby given to Presence Developmental Services and Presence Counseling Services staff and its service providers to render screening, assessment, treatment, and support services to the above-named individual and under the above-named conditions.

_____

Signature of Individual

_____ _____

Signature of Parent or Legal Guardian Relationship to Individual

_____ _____

Witness Date

If you have any questions, please contact Cecily at 315-515-5183 or info@presencedevelopmental.com .

PRESENCE REFERRAL PACKET

Screening and Mental Status Exam for Children and Teens

Identify the individual's symptoms, the frequency (i.e. 3 times per day), and severity of problems by scoring on a scale from 1 to 10 with 10 as the most severe.

Activity

_____( ) Hyperactivity
_____( ) restless such as squirming in seat
_____( ) impulsive: acts without thinking
_____( ) fidgets such as hands always busy
_____( ) ticks or unusual activities
_____( ) jokes inappropriately
_____( ) recent increase in activities: work, sex, social
_____( ) loss of energy or fatigue
_____( ) loss of motivation: no interest in activities
_____( ) bored and uninterested

Relational

_____( ) drop in grades
_____( ) lost a job
_____( ) legal problems
_____( ) theft (in or out of home)
_____( ) dishonesty or lying
_____( ) dangerous or risk-taking behavior
_____( ) missing or cutting school
_____( ) physically abusive to others
_____( ) conflict with parents or teachers
_____( ) destructive: hits or breaks things
_____( ) threatens to harm or kill others
_____( ) cruel to animals or other children
_____( ) suspensions from school
_____( ) fights with peers or siblings
_____( ) self-injurious: cuts, burns, tattoos, etc.
_____( ) threats to kill self
_____( ) suicide attempt
_____( ) blames others for own behavior
_____( ) lonely or difficulty attaching to others
_____( )poor social skills
_____( ) defies authority
_____( ) withdrawn from family or friends
_____( ) ridiculed by peers

Anxiety/Phobia

_____( ) nervous or anxious
_____( ) afraid of a lot of things
_____( ) afraid of a specific thing:
_____( ) worries often about:
_____( ) panic attacks
_____( ) feels disliked or criticized

Sleep

_____( ) marked change in sleeping habits
_____( ) difficulty falling asleep
_____( ) wakes up early & can't fall back asleep
_____( ) sleeps too much:____ hrs. per night
_____( ) sleeps too little: _____hrs. per night
_____( )bad dreams or night terrors

Appetite

_____( ) binge eating
_____( ) self-induced vomiting
_____( ) loss of appetite
_____( ) increase in appetite
_____( ) weight gain: _____lbs.
_____( ) weight loss: _____lbs.
_____( ) dislikes own appearance or body size

MIND/SPEECH/THOUGHTS

_____( ) poor concentration/ easily distracted
_____( ) difficulty focusing on school work
_____( ) poor problem-solving skills
_____( ) difficulty making decisions
_____( ) makes poor decisions
_____( ) accident prone
_____( ) forgets easily
_____( ) memory loss of significant events
_____( ) does not acknowledge own problems
_____( ) racing thoughts
_____( ) talks excessively

Thought Content/Perceptions

_____( ) grandiosity
_____( ) strange or unusual ideas
_____( ) delusions or false beliefs
_____( ) thoughts of suicide
_____( ) avoids eye contact
_____( ) hallucinations
_____( ) reoccurring thoughts or play of distressing events
_____( ) paranoia: thinks others will injure self

Physical

_____( ) physical complaints: stomach, head, etc.
_____( ) aches and pains
_____( ) sweaty palms
_____( ) auto or other accidents

_____( ) obsessive behaviors: counting, touching, exercising, etc.
_____( ) smells of paint/other chemicals

Mood

_____( ) angry
_____( ) grouchy or irritable
_____( ) depressed mood
_____( ) strong guilt feelings
_____( ) feels as if she/he is bad
_____( ) mood swings
_____( ) tearfulness
_____( ) hopeless or helpless
_____( ) dislikes self
_____( ) feels unloved or un-liked
_____( ) overestimates own abilities
_____( ) elevated mood

_____( ) health problems: _____
_____( ) doesn't give adequate care to hygiene
_____( ) onset of puberty :_____
_____( ) developmental delays or growth spurts
_____( ) difficult pregnancy _____
_____( ) prenatal drug use (by mother)
_____( ) child is sexually active or acting out
_____( ) soiling or bed wetting
_____( ) reoccurring respiratory problems
_____( ) suspect drug or alcohol use
_____( ) cigarette use: amt. _____
_____ ( ) OTHER _____

Provider name, title, and date _____

PRESENCE REFERRAL PACKET

Screening and Mental Status Exam for Adults

Symptoms Checklist: Please indicate what symptoms you are experiencing and the severity by making it with a number between 1 and 10 with 10 being the most severe.

Activity:

____Decrease in energy or fatigue
___Hyperactivity
___Impulsive
___Restless
___Physically slowed
___Physically agitated
___Excessive social, work, or playful activities

Behaviors:

___Work difficulties
___Aggressive
___Violent
___Compulsions
___Dishonesty or theft
___Destructive
___Disorganized
___Oppositional or defiant
___Reckless
___Self-injurious
___Violation of the rules or rights of others
___Legal problems

Anxiety

___Anxiousness
___Fear of separation
___Jitteriness
___Panic attacks
___Phobias
___Worry about _____

Mood

___Mood swings
___Angry
___Tearfulness
___Depressed mood
___Excessive guilty
___Elevated mood
___Feeling worthless
___Helpless
___Hopeless

Sleep Disturbance

___Early morning waking
___Hypersomnia
___Insomnia

Memory/ Attention

___Easily Distracted
___Difficulty Concentrating
___Indecisive
___Poor judgment
___Memory loss

Thought and Speech

___More talkative than usual
___Urge to keep talking
___Racing thoughts
___Confused thinking
___Slurred speech

Perceptions and Thought Content

___Delusions
___Hallucinations (visual, sounds, touch, smells, etc.)
___Bizarre or unusual thoughts
___Obsessive thoughts
___Paranoid thoughts
___Not feeling real/ depersonalization
___Grandiose thoughts
___Thoughts of suicide or death
___Thoughts of a distressing event or flashbacks

Eating Disturbances

___Binge eating
___Loss of appetite
___Increase in appetite
___Inability to maintain a stable body weight
___self-induced vomiting

Substance Use

Type _____
___Work or family conflict over use
___Inability to decrease use

___Irritability ___Persistent desire for substance
___Hostility ___An increase in tolerance
___Loss of interests ___Withdrawal symptoms
___Loss of pleasure or apathy ___Excessive time to obtain, use, or recover
___Low self-esteem ___Legal problems _____

Provider name, title, and date _____

PRESENCE REFERRAL PACKET

PHQ-9 Patient Questionnaire

In an effort to provide the highest standard of care and meet the requirements of your insurance company, we ask that you fill out the form below. This form is used as both a screening tool and a diagnostic tool for depression. Your provider will discuss the form with you during your visit. Thank you for your cooperation and the opportunity to care for you.

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling/staying asleep, or sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Add columns ___ + ___ + ___ + ___

= _____ Total score

Total Score and Depression Severity: 1-4 minimal 5-9 mild 10-14 Moderate 5-19 moderately severe 20-27 severe

If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Health Information

By law, Presence Services ("Company") is required to:

- Maintain the privacy and security of your Protected Health Information (including Medicaid Confidential Data)
- Provide you with notice of our legal duties and privacy practices with respect to Protected Health Information
- Notify you following a breach of your Protected Health Information and
- Follow the terms of the Notice that is currently in effect.

With your consent, we may use and disclose your Protected Health Information for the purposes of treatment, payment, and healthcare operations as described below.

- ✓ Treatment: We can use and share your information with other professionals who are treating you. Example: Our care coordinator may speak to a nurse about your medications.
- ✓ Payment: We can use and share your health information to bill for services and receive payment. Example: We may include your health information when we bill Medicaid for our services.
- ✓ Health Care Operations: We may use and disclose your information to others for our business operations. Example: We may use your health information to improve the quality of our services.

Presence Services may also use and disclose your Protected Health Information for other specific purposes that are required or permitted by law. These include for the purposes of:

1. Promoting public health and safety (e.g., preventing disease, adverse reactions to medications, reporting suspected abuse)
2. complying with the law (e.g., if state or federal law requires it)
3. assisting coroners, medical examiners, funeral directors, and organ procurement agencies (e.g., assisting in autopsies or organ donations)
4. complying with government requests (e.g., for workers' compensation claims, law enforcement purposes, health oversight agencies).

Authorization

We may use and disclose your Protected Health Information for purposes other than as described in this Notice or required by law only with your written authorization. You may revoke your authorization to use or disclose Protected Health Information in writing at any time.

Rights

You have certain rights concerning the use and disclosure of your Protected Health Information. The law describes them in more detail, but generally, they are:

- The right to request restrictions on certain uses and disclosures of your Protected Health Information (although we do not have to agree with them)
- The right to request confidential communications (such as designating a certain telephone number or email address) if your request is reasonable
- The right to inspect or obtain an electronic or paper copy of your Protected Health Information. We may charge a reasonable, cost-based fee
- The right to amend your Protected Health Information under limited circumstances specified by law

If you have any questions, please contact Cecily at 315-515-5183 or info@presencedevelopmental.com .

- The right to receive an accounting of disclosures of Protected Health Information for six years prior to the date you ask for all disclosures except those made for purposes of treatment, payment, or healthcare operations
- The right to receive a paper copy of this Notice at any time.
- If you have designated someone as your Health Care Proxy or if someone is your legal guardian or surrogate, that person can exercise your rights and make choices about your health information, if the person has the required authority.

Complaints

You may complain if you feel we have violated your rights by contacting us using the contact information listed in this Notice. You may also file a complaint with the Secretary of the United States Department of Health and Human if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Amendments

We reserve the right to amend this Notice and to make the new Notice provisions effective for all your Protected Health Information maintained by us.

Contact Information

For more information about Provider's privacy practices, please contact:

Rachelle Santana, Privacy Officer

815-515-5183 or rsantana@presencedevelopmental.com

Effective Date of this Notice: 2018