Application for Adult Services – Instructions

The Department of Mental Health (DMH) provides services and supports to adults with serious and persistent mental illness to enable persons to live independently in the community.

Individuals 18 years of age or older who request mental health services through DMH must submit the following completed forms, with signatures and dates where indicated:

- Request for Adult Services application
- DMH Service Authorization Determination (page 6)
- Authorization(s) for Release of Information

To expedite the determination, DMH encourages applicants to also submit relevant medical information and documents such as:

- Psychiatric assessment completed by a licensed clinician within the previous six months, and/or
- Hospital admission/discharge reports if hospitalized during the previous six months

While submitting medical information at the time of a request for services is not required, it is strongly recommended the information be submitted at the same time. DMH will need to review such medical information and will require such information at a later date.

If you are a provider of mental health care and making a referral to DMH, please follow the instructions on page two.

Within seven (7) days of receipt of a Request for Adult Services application, DMH will contact the applicant or guardian by telephone. The purpose of the phone contact will be to:

- Acknowledge DMH’s receipt of the Request for Adult Services application
- Review the determination process
- Confirm the applicant wants to continue the determination process
- Assess the applicant’s immediate or emerging needs and respond as appropriate
- Initiate the collection of relevant medical and other information that supports the applicant’s request for services.

A DMH Clinical Service Authorization Specialist may request, as necessary, a face-to-face meeting with the applicant and/or guardian to further discuss and assess the needs of the applicant. In most instances, a face-to-face meeting will occur at a DMH office. In other instances, a face-to-face meeting may occur at another agreed upon location.

The DMH Area Director or designee in the Area where the applicant is applying for services will make decisions regarding service requests upon receiving and reviewing information in accordance with DMH regulations.
Since the availability of DMH services is limited, DMH must prioritize to whom and how those services are provided. DMH regulations establish the criteria to be used to determine who is authorized to receive DMH services and how those services are assigned.

A completed Request for Adult Services application, a signed DMH Service Authorization Determination form, and Authorization for Release of Information forms must be delivered, mailed or faxed to the DMH Area or Site Office with responsibility for the community where the applicant or guardian resides at the time of application.

Application materials are available in all DMH Area and Site Offices, acute inpatient psychiatric facilities, in many community programs throughout the Commonwealth and can be downloaded from the DMH website at www.state.ma.us/dmh. Applications are available in English. DMH can provide translators for other languages if necessary and provide other assistance as needed.

**Additional Instructions for Providers of Mental Health Care**

A provider of mental health care who makes a referral to DMH must submit relevant clinical information including:

For applicants currently at an inpatient facility

☐ Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V)
☐ Any other assessments (e.g. psychosocial, medication, neuropsychological testing, neuropsychological examinations, etc.)
☐ Hospital Course, including treatment plan

For applicants who currently reside in the community

☐ Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V)
☐ Any other assessments (e.g. psychosocial, medication, neuropsychological testing, neuropsychological examinations, etc.)
☐ Discharge summary, if hospitalized during the previous six months
☐ Current mental health treatment plan

Providers of mental health care who make a referral to DMH must ensure that signed Authorization for Release of Information forms are included for all clinical information submitted with the request for services. The submission of release forms at the time of application for other documents DMH will need to obtain will facilitate the determination process for the applicant. DMH may also request additional clinical information as necessary.
Race and Ethnicity Categories

The following categories may be used to complete the “Race” and “Ethnicity” categories on the DMH Application for Adult Services. In filling out the application, please be advised of the following:

This information is requested so that DMH may better provide person-centered services that are culturally and linguistically appropriate. It also helps the Department comply with regulations and standards, and allows for the planning of any unmet service needs.

Persons who are of more than one race or ethnicity are invited to identify as such.

The provision of this information is optional. You may choose whether or not to provide this information. Your decision to do so, or not to do so, will not affect your application for DMH services in any way.

RACE

The following designations come from the federal government:

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black OR African American</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Black/Hispanic</td>
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<tr>
<td>American Indian/Alaska Native</td>
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<tr>
<td>Pacific Islander/Hawaiian</td>
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<tr>
<td>White/Hispanic</td>
</tr>
<tr>
<td>White/Non-Hispanic</td>
</tr>
</tbody>
</table>

ETHNICITY

Ethnicity is defined as the group of people who you are connected to by a common national origin, history, language or customs and cultural experiences. The following are some examples of ethnicity or ethnic groups:

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Albanian</td>
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<td>Armenian</td>
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<td>Bosnian</td>
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<td>Brazilian</td>
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<td>Cambodian</td>
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<td>Chinese</td>
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<td>Colombian</td>
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<td>Congolese</td>
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<td>Costa Rican</td>
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<td>Portuguese</td>
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<td>Salvadoran</td>
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<td>Ukrainian</td>
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<td>Venezuelan</td>
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<tr>
<td>Vietnamese</td>
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<tr>
<td>West Indian/Caribbean</td>
</tr>
</tbody>
</table>
Commonwealth of Massachusetts  
Department of Mental Health (DMH)  
REQUEST FOR ADULT SERVICES  
Effective October 2009

Personal Information

Name ____________________________  SSN ____________________________

(Last)  (First)  (Middle)  (Social Security Number)

Address _____________________________  _____________________________  ____________  ____________  ____________  ____________

(Number and Street)  (Apt No)  (City)  (State)  (Zip Code)

How may we contact you? (Please check all that apply and provide phone number/e-mail address)

☐ Day/Work Phone ( ) ____________________________  May we leave a message? Yes ☐  No ☐

☐ Evening Phone ( ) ____________________________  May we leave a message? Yes ☐  No ☐

☐ Cell Phone ( ) ____________________________  May we leave a message? Yes ☐  No ☐

☐ e-mail ________________________________________________________________________________

Birth Date __/__/____  Age _____  Gender _____  Race ___________  Ethnicity ___________  Marital Status ___________

Preferred Language _________________________________________________________________________  Do you speak English?  Yes ☐  No ☐

Do you speak English?  Yes ☐  No ☐

Are you deaf or hard of hearing?  Yes ☐  No ☐  Do you need interpreter services?  Yes ☐  No ☐

Have you ever served in the military?  Yes ☐  No ☐  Unknown ☐

Do you have a court appointed legal guardian?  Yes ☐  No ☐  If yes, what type? ________________________________________________________________________________

If yes, please submit a copy of the guardianship decree with this application. The legal guardian must sign the application and all the releases of information for the application to be processed.

Name of Legal Guardian ____________________________________________  Relationship ____________________________

(Last)  (First)  (Relationship to Applicant)

Guardian’s address ______________________________________________

(Number and Street)  (Apt No)  (City)  (State)  (Zip Code)

How may we contact the guardian? (Please check all that apply and provide phone number/e-mail address)

☐ Day/Work Phone ( ) ____________________________  May we leave a message? Yes ☐  No ☐

☐ Evening Phone ( ) ____________________________  May we leave a message? Yes ☐  No ☐

☐ Cell Phone ( ) ____________________________  May we leave a message? Yes ☐  No ☐

☐ e-mail ________________________________________________________________________________  May we send a message? Yes ☐  No ☐

Name of Emergency Contact ____________________________________________  Phone # ____________________________

(First)  (Last)

Please Include a Release of Information

Health Insurance

No health insurance ☐

Application for Health Insurance Pending ☐  Please specify insurance: ____________________________

Medicaid ☐  If Medicaid and under 21, is applicant currently enrolled in a CSA?  ☐  Please identify: __________

Medicare/Medicaid ☐

Medicare ☐

Private Insurance: ☐  Please specify insurance: ____________________________

Source of Income

Employment ☐  Family ☐

SSDI ☐  Emergency Aid ☐

SSI ☐  Other ☐  Please specify: ____________________________

Social Security ☐  No Income ☐

If you are a parent or step parent, are there children living in the home? Yes ☐  No ☐  Not Applicable ☐

Are you currently involved with another state agency? Yes ☐  No ☐  Unknown ☐

If yes, which agency?  DCF ☐  DDS ☐  EOEA ☐  DPH ☐  DYS ☐  MRC ☐  MCDHH ☐  MCB ☐  VA ☐

Check all that apply.
Are you currently in a hospital?  Yes ☐  No ☐  If yes, where? __________________________
Are you currently homeless?  Yes ☐  No ☐  Involved agency, if any: __________________________
Are you currently incarcerated?  Yes ☐  No ☐  If yes, where? __________________________
Are you currently on probation?  Yes ☐  No ☐  If yes, probation officer name __________________________
Is this a 688 referral?  Yes ☐  No ☐  If yes, list LEA __________________________

**Primary Mental Health Care Provider:** Please indicate who provides your regular mental health care. If there is no regular source of mental health care, use this section to indicate your most recent source of mental health care.

Primary Mental Health Provider ___________________________________________  Current provider? Yes ☐  No ☐

(First)  (Last)

Address ________________________________________________________________

(Number and Street)  (Apt No)  (City)  (State)  (Zip Code)

Telephone Number (          ) __________________________ Extension _________

Do you have a current psychiatric diagnosis?  Yes ☐  No ☐  Unknown ☐
If yes, what is it? __________________________

**General Physical Health:** Please indicate who provides your regular physical health care. If there is no regular source of physical health care, use this section to indicate your most recent source of medical care.

Primary Medical Care Provider ____________________________________________  Current provider? Yes ☐  No ☐

(First)  (Last)

Telephone Number (          ) __________________________ Extension _________

Do you have any medical problems that require regular care?  Yes ☐  No ☐  Unknown ☐
Have you ever had a diagnosis of a neurological problem?  Yes ☐  No ☐  Unknown ☐
If yes, please describe any current medical or neurological problems: __________________________

**Medications:** Are you currently taking any medications?  Yes ☐  No ☐  Unknown ☐
If yes, please list medications. __________________________________________________________

If yes, who is currently prescribing these medications? __________________________

**Why are you applying for services?** (check all that apply and use space below to add your own comments)

I am involved in mental health outpatient services but feel I need additional assistance ☐
I am not involved in mental health services and feel I need to be ☐
I am looking for services to help me gain control of my life ☐
Other people think I may need services ☐

What kind of services do you think are needed?  ________________________________________________
REQUEST FOR ADULT SERVICES

DMH SERVICE AUTHORIZATION DETERMINATION

Applicant Name:

- I request that the Department of Mental Health (DMH) conduct a DMH service authorization determination. I have attached signed Authorization for Release of Information forms to this application if necessary. I understand that DMH will collect and review medical records as part of the determination process. I understand that my name and information about me will be included in a DMH record keeping system.
- DMH may request a personal interview with me or a clinical evaluation in circumstances where the available clinical records are not sufficient to make a determination.
- I will be required to disclose information about my income and insurance and may be charged for services according to my ability to pay.
- I understand I may appeal the decision of DMH when it is determined the applicant is not approved for services because they do not meet the criteria for DMH services.
- I received a copy of the DMH Notice of Privacy Practices (appended to this request for services).
- I give permission to DMH to communicate about my request for DMH services with the person identified below who assisted with this application. This permission is valid until my application is fully processed or unless I notify DMH in writing that I revoke it.

Signature of applicant or legal guardian of the person
Applicant Name (Print) Date signed

PERSON ASSISTING APPLICANT
This section to be completed by the provider or other person assisting the applicant with the application.

Name ____________________________ Relationship ____________________________
(Last) (First) (Relationship to Applicant)
Address ________________________________________________________________
(Number and Street) (Apt No) (City) (State) (Zip Code)
Telephone ( ) ___________________________ Day ☐ Evening ☐ Cell ☐

PROGRAM OR FACILITY SUBMITTING APPLICATION ON BEHALF OF APPLICANT
This section to be completed by the program or facility submitting the application on behalf of applicant.

Name of Program or Facility ____________________________ Name of Applicant ____________________________
☐ The applicant was informed on ______________ that an application was being filed on his/her behalf and he/she did not object
☐ The applicant lacks capacity and a petition for guardianship was filed in the appropriate court (copy of petition is attached)

Your Name (please print) ____________________________ Your Signature and Title ____________________________

TO SUBMIT RELEASE OF MEDICAL INFORMATION FORMS
As part of the request for DMH Services determination process, the Department of Mental Health will review records of all mental health care received by the applicant. Please submit signed Authorization for Release of Information forms along with the application, if possible.

1. Please submit one signed Authorization for Release of Information form for each provider of mental health care. If mental health care is provided through a clinic, please identify a primary provider of care at that clinic.
2. In addition, please submit an Authorization for Release of Information form for any other clinical information the applicant would like to have considered as part of the determination.
3. Please check the accuracy of the provider’s name, address, and phone number on each release form. Correct names, addresses and phone numbers expedite the review process.

How many Authorization for Release of Information forms are being submitted with this application? ☐

The Department will also review any medical records that the applicant or those assisting the applicant may have in their possession and wish to submit for consideration.

1. Please complete and sign an Authorization for Release of Information form for each medical record that is attached to this application in case DMH staff need to clarify information contained in the report.
2. Copies of medical reports cannot be returned so please do not send original copies.

How many copies of medical reports are attached to this application?
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: Other Name(s):
Address: Phone:
Social Security #: Date of Birth:

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: Attention: Phone:
Street: City/Town: State: Zip:

DMH Contact Information:
Name: Phone:
Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

Purpose for the authorization:
☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)
or
☐ Coordinate care ☐ Facilitate billing
☐ Referral ☐ Obtain insurance, financial or other benefits
☐ Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information: ________________________________

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event)_________________________ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X ________________________________________________  __________________________
Your signature or Personal Representative’s signature  Date

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) ________________________________________

Specially Authorized Releases of Information (please initial all that apply)

_____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

_____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

__________________________                 ______________________
Your signature or Personal Representative’s signature    Date

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

DMH Authorization for Release of Information-Two Way
HIPPA-F-4 (4/22/03)
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: Attention: Phone:

Street: City/Town: State: Zip:

DMH Contact Information:

Name: Phone:

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Purpose for the authorization:

☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

☐ Coordinate care ☐ Facilitate billing

☐ Referral ☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information:
__________________________________________________________

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event)_________________________ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X __________________________________________________________  __________________________
Your signature or Personal Representative's signature    Date

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) ________________________________________

Specially Authorized Releases of Information (please initial all that apply)

____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

_______________________________________                 ______________
Your signature or Personal Representative's signature    Date

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

DMH Authorization for Release of Information-Two Way
HIPPA-F-4 (4/22/03)
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: Other Name(s):
Address: Phone:
Social Security #: Date of Birth:

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: Attention: Phone:
Street: City/Town: State: Zip:

DMH Contact Information:
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Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Purpose for the authorization:
☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)
or
☐ Coordinate care ☐ Facilitate billing
☐ Referral ☐ Obtain insurance, financial or other benefits
☐ Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information: ___________________________

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event) __________________ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X

Your signature or Personal Representative’s signature

Date

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) __________________________

Specially Authorized Releases of Information (please initial all that apply)

_____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

_____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

Your signature or Personal Representative’s signature

Date

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

DMH Authorization for Release of Information-Two Way
HIPPA-F-4 (4/22/03)
Commonwealth of Massachusetts
Department of Mental Health

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.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: December 15, 2010
Version 6

Privacy
The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice
DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.state.ma.us/dmh), and will be available on request. Every privacy notice will be dated.
How Does DMH Use and Disclose PHI?
DMH may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations
The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to help make a determination on your application for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with DMH service providers for the purposes of referring you for DMH services and then for coordinating and providing the DMH services you receive.

To obtain payment - Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders
DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization
DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.

Exceptions
- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
  - Clergy – Your religious affiliation may be shared with clergy
  - To Family and Friends – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate
For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
If required by law, or for law enforcement or national security
To EOHHS and/or its agencies, such as MassHealth, DCF, DDS, DYS, DTA and DPH for functions including service delivery, eligibility and program management.
To avoid a serious and imminent threat to public health or safety
For public health activities such as tracking diseases and reporting vital statistics
Upon death, to funeral directors and certain organ procurement organizations

Your Rights
You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

• Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
• Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
• *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
• *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
• *Receive a list of individuals who received your PHI from DMH (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
• *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

* These requests must be made in writing

Record Retention
Your individual records relating to DMH provided care and services will be retained at a minimum for 20 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To Contact DMH or to File a Complaint
If you want to obtain further information about DMH’s privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, Phone: 617-626-8160, Fax: 617-626-8131, E-mail: PrivacyOfficer@dmh.state.ma.us. A complaint must be made in writing.

You also may contact a DMH facility’s medical records office (for that facility’s records), a DMH program director (for that program’s records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA. 02203.