

REFERRAL FOR CHILDREN and FAMILIES TREATMENT SUPPORT SERVICES (CFTSS)

Vanderheyden, is accepting referrals from the community for children who may benefit from the new NYS Children and Family Treatment Support Services (CFTSS.) Children and youth who are covered by Medicaid and have mental health and/or substance use needs can get CFTSS. CFTSS Services are intended to support and stabilize a child in the community. Services can be delivered in their natural environment including, home, school or other community setting. **Services must be recommended and signed by a Licensed practitioner of the Healing Arts (LPHA)**

Current Available Services include:

1. **Other Licensed Practitioner (OLP):** Assessments for mental health and/or substance use needs, identifying strengths and abilities through individual and group therapies, individual, group or family therapy where most comfortable.
2. **Community Psychiatric Supports and Treatment (CPST):** CPST are goal directed supports and solution focused counseling services intended to address challenges associated with mental health needs and to achieve goals set forth in a child's treatment plan
3. **Psychosocial Rehabilitation (PSR):** PSR services are hands-on support interventions intended to teach skills and restore and rehabilitate a child's social, interpersonal, and community functioning
4. **Family Peer Support Services (FPSS):** FPSS are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community.
5. **Youth Peer Support and Training (YPST):** YPST services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services.

To Make A Referral:

This form allows a LPHA to complete a referral and medical necessity in the same place while obtaining consents to treat. In order for the referral to be complete, the LPHA must sign and attest to medical necessity that determines the need for CFTSS services for the child and their family.

Assistant Director of CFTSS/CMHRS- Anna Carey, LCSW

Email: acarey@vanderheyden.org Phone: 518-286-7630 Fax: 518-326-2294

Children Family Treatment Support Services (CFTSS) Referral and Medical Necessity

Child's Information:

Date of Referral:		Date of Birth:		Gender:	
Child's Name (Last, First, M.I.):					
Address:					
Phone Number:		SSN:		Primary Language:	

Parent/Legal Guardian Information:

Parent/Guardian's Name (Last, First, M.I.)			
Address:		Phone Number:	

Referral Source Information:

Name:		Agency:	
Email:		Phone Number:	

Insurance Information:

Managed Care Organization:		Medicaid CIN#	
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Behavioral Health Information: (A MH/SUD diagnosis is only required for a recommendation of PSR)

Diagnosis Order:	Diagnosis Category	Diagnosis/Symptoms of Mental Illness or Substance Use	ICD 10 Code
Primary:			
Secondary:			
Other:			

Areas of Functioning:

Check	Domain:	Description of Impairment
	Self-Direction/Self Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended Services and Service Frequency:

Service Category	Service Type	Recommended?	# of days/week
Other Licensed Practitioner:	Licensed Evaluation (Assessment)		
	Psychotherapy (Individual, Family, Group)		
	Crisis Intervention		
Community Psychiatric Support Services:	Intensive Interventions (Individual and Family Counseling)		
	Crisis Avoidance		
	Intermediate Term Crisis Management		
	Rehabilitative Psychoeducation Services		
	Strength Based Service Planning		
	Rehabilitative Supports		
Psychosocial Rehabilitation:	Personal and Community Competence		
	Social and Interpersonal Skills		
	Daily Living Skills		
	Community Integration		
Family Peer Support Services:	Engagement, Bridging, Transition Support		
	Self-Advocacy, Self-Efficacy, Empowerment		
	Parent Skill Development		
	Community Connections and Natural Supports		
Youth Peer Support and Training:	Skill Building		
	Coaching		
	Engagement, Bridging, Transition Support		
	Self-Advocacy, Self-Efficacy, Empowerment		
	Community Connections and Natural Supports		

Reason for Recommendation:

****By signing below, I am attesting medical necessity and recommending the above-named individual for Children Family Treatment Support Services.**

LPHA Signature:	Printed Name:
NPI #	License #
Email	Date
Phone Number	

Consent to Refer: Verbal consent to make this referral must be obtained from the parent/guardian/legally authorized representative for children up until the age of 18. For children/youth ages 18-21 or that are married, a parent or pregnant may consent on their own behalf. **Who has provided you with the consent to make this referral to Vanderheyden?**

Parent:		Guardian:		Legally Authorized Representative:		Child/Youth:	
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There are a number of providers available for Children and Family Treatment Support Services. You have the right to select a provider that you feel will work best with you and your family. Select the provider below. Please initial next to the provider you select.

	Vanderheyden
	St. Catherine's Center for Children
	Berkshire Farm Center and Services for Youth
	Cayuga Home For Children DBA Inc., Cayuga Centers
	La Salle School
	Northeast Parent & Child Society Inc
	St. Anne's Institute

Print Name:

Signature:

Relationship to youth:

Date:

Authorization for Release of Information

Name: _____ **DOB:** _____

This authorization must be completed by the individual or his/her personal representative to use/disclose/obtain protected health information (for 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.

I, _____ authorize Vanderheyden to:

Obtain Information-

Disclose Information-

Information to be obtained/disclosed:

Treatment goals	Discharge summary/discharge plan	Complete medical records
Safety plans/behavior management plans	Description of progress and prognosis	Medical history and physical consultation reports.
Psychiatric evaluation	Assessment/Screening	Individualized Education Plan
Medication management	Educational/psychological testing	Laboratory tests
Psychosocial assessment	Other:	

The purpose of obtaining or disclosing information:

To provide ongoing communication with referring agency	To convey treatment recommendations and progress	To complete an evaluation (alcohol/drug, psychiatric, psychological, etc.)
To contact in case of emergency	To maintain continuity of care	To provide ongoing treatment aftercare
For treatment planning purposes	Other:	

This consent will remain in effect until discharge from Vanderheyden's CFTSS program. In order to revoke this authorization, a request must be completed in writing.

I hereby permit the use or disclosure of the above information to the person/organization/program(s) identified above. I understand that:

- Only this information may be used/obtained/disclosed as a result of this authorization.
- This information is confidential and cannot be legally be disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by Vanderheyden. 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 acted because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Vanderheyden, nor will it affect my eligibility for benefits.
- I have the right to inspect and copy my own protected health information to be used and/or disclosed as stated by law and or regulation.
- I have the right to receive a copy of this release of information.

Signature of Individual

Parent/Guardian/Authorized Rep

Signature of Witness

Date:

Notice of Privacy Practices Vanderheyden

THIS NOTICE DESCRIBES HOW HEALTH AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Our Commitment to You: We at Vanderheyden understand that the information we collect about you and your health is personal. Keeping your health information confidential and secure is one of our most important responsibilities.

We keep a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting your health information and to following all state and federal laws regarding the protection of your health information. This notice tells you how we may use or release your health information. It also tells you about your rights and requirements concerning the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect
- If you have any questions about this notice, please contact the Assistant Executive Director at (518) 283-3458, ext. 11.

2. Who will follow this notice: This notice describes the practices of Vanderheyden and that of:

- Any student or member of a volunteer group we allow to help you while you are in our care

3. Your Health Information Rights:

You have the following rights regarding health information we have about you:

RIGHT to Inspect and Obtain Copies: You have the right to inspect and obtain a copy of health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal, or administrative actions or proceedings. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

- To inspect or obtain a copy of health information that may be used to make decisions about you, you must submit your request in writing to the Associate Executive Director.
- We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. The Medical/Clinical Team will review your request and the denial. The person(s) conducting the review will not include the person who denied your request. We will comply with the outcome of the review.

RIGHT to Amend: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as the information is kept by or for us.

- To request an amendment, your request must be made in writing and submitted to Associate Executive Director. In addition, you must provide a reason that supports your request.

RIGHT to an Accounting of Disclosures: You have the right to request a list of information releases that we have made of your health information. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for the purpose of treatment, payment, or health care operations. You also have the right to request that we restrict or limit health information about you that we may use or disclose to someone who is involved in your care or the payment for your care, such as a family member. Please be aware that we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

RIGHT to Request Confidential Communications: You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain phone number or by mail.

RIGHT to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You

- May ask us to give you a copy of this notice at any time. Even if you have agreed to receive
- This notice electronically, you are still entitled to a paper copy of this notice.
- You may obtain a copy of this notice at our website, www.vanderheydenhall.org

Use or Disclose of Your Health Information:

For Treatment: Caregivers, such as nurses, doctors, therapists and social workers, may use your health information to determine your plan of care. Individuals and programs within Vanderheyden Hall may share health information about you to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or transfers or referrals for follow-up care. We may use health information about you to provide you with treatment or services.

For Payment: Vanderheyden may release information about you to your health insurance carrier or agency responsible for paying for your care, i.e. DSS to obtain payment for our services. For example, we may need to give your health plan information about a clinical exam or medications that you received so your health plan will pay us for treatment or services we provided. We may also share your information, when appropriate, with other government programs such as Medicaid to determine if you are eligible for, or to coordinate, your benefits, entitlements, and payments. We may need to disclose a limited amount of information about you to explore your financial situation for possible sources of payment for your care, but we will only do so as permitted under law. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Operations: Vanderheyden may use and release information about you to ensure that the services and benefits provided to you is appropriate and are high quality. For example, we may use your information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine health information about many individuals to research health trends, or determine what services and programs should be offered, or whether new treatments or services are useful. We may share your health information with our business partners who perform functions on our behalf.

FAMILY FOCUSED • TRAUMA INFORMED • COMMUNITY BASED

To Keep You Informed: Unless you provide us with alternative instructions, we may contact you about reminders for treatment, medical care, or health check-ups. We may also contact you to tell you about health-related benefits or services that may be of interest to you or to give you information about your health care choices.

Business Associates: We provide some services through contracts with business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associates to appropriately safeguard health information.

To Other Government Agencies Providing Benefits or Services: We may release your health information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits or services.

As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may release your health information if it is necessary to prevent a serious threat to your health or safety or to the health and safety of the public or another person.

For Public Health Activities: We may disclose health information about you to public health agencies, subject to the provision of applicable state and federal law, such as prevention or to control disease, injury or disability; child abuse or neglect; reactions to medications or problems with products to the Food and Drug Administration (FDA).

For Law Enforcement: We may release health information to a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or other similar process
- To identify or locate a suspect, fugitive, material witness, or missing person about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About criminal conduct at the agency
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Medical Examiners and Others: We may release health information to a coroner or medical examiner to carry out their duties. If you are an organ donor, we may release your health information to an organization that help with organ eye, or tissue donation or transplantation.

National Security and Protection of the President: We may release your health information to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.

For Privacy Violations	For Additional Copies or More Privacy Information
Jenny Wiegert, Director of Quality Assurance	Maura Psoinos, Vice President of Community Services
Vanderheyden, Inc.	Vanderheyden Inc.
PO Box 219, Route 355 Wynantskill, NY 12198	1801 6th Avenue Troy NY 12180
(518)-283-6500 ext. 267	(518)-286-7641

Inability to Obtain Acknowledgement: If the individual served or their parent or personal representative refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the acknowledgement and the reasons why the acknowledgement was not obtained:

Individual/representative refused to sign Acknowledgement

Individual/representative unable to sign Acknowledgement

Other (explain): _____

Name of Individual/representative: _____

Signature of Person who attempted to obtain Acknowledgement: _____

Date: _____



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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Vanderheyden

Name of Individual Served

Signature (Individual, parent or personal representative and relationship)

Date: _____

This document may be mailed or faxed to Vanderheyden Fax number is 518-283-7156