

Dear Provider,

Thank you for making a referral to case management services at Frannie Peabody Center. By completing this referral packet, you will allow us to expeditiously begin the process of enrollment in case management services. Once the referral is made, the client will be contacted by a case manager to schedule an intake appointment.

Please include:

- A copy of client's most recent CD4 and viral load lab results
- Verification of HIV Status form
- Request for Case Management Services form
- Acuity Scale for Provider Referrals
- A signed release of information in order for Frannie Peabody Center to follow up with you about this referral.
- Any additional releases that may help us connect with this client (i.e. for Optimal Interpreter services if client has English as a second language, etc).

This information can be faxed to 207-879-0761 or send by mail to:

Charlotte Rogers
Case Management Supervisor
Frannie Peabody Center
30 Danforth St, Suite 311
Portland, ME, 04101

If you have any questions about these forms or our services in general, please do not hesitate to contact Charlotte Rogers at 207-749-5163.

Sincerely,

Frannie Peabody Center Case Management Team

FRANNIE PEABODY CENTER
Release/Authorization to Use/Disclose Confidential Information

Client Name: _____
Date of Birth: _____ File #: _____

I authorize Frannie Peabody Center and their authorized employees to:

(Check one below)

- | | |
|--|---|
| <input type="checkbox"/> Both Release information to and Obtain from
<input type="checkbox"/> Release information to
<input type="checkbox"/> Obtain information from | Name: _____
Street: _____
City: _____
State/Zip: _____ |
|--|---|

Intent/Purpose of this authorization: Medical care coordination
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Share the following information (check those that apply):		
<input checked="" type="checkbox"/> Medical, Medication, Labs and Test Results	<input type="checkbox"/> Housing information	<input checked="" type="checkbox"/> Income and Financial status
<input checked="" type="checkbox"/> Other: Insurance		

	Initials here <u>ONLY</u> if: You DO NOT want to disclose this info
I DO authorize the disclosure of information relating to HIV infection status or treatment information	I DO NOT: _____ (initial here)
I DO authorize the disclosure of information relating to ALCOHOL or DRUG ABUSE diagnosis or treatment.	I DO NOT: _____ (initial here)
I DO authorize the disclosure of information relating to MENTAL HEALTH diagnosis or treatment.	I DO NOT: _____ (initial here)

Exclude the following information: _____

I understand that:

- I can refuse to disclose some or all the health care information in my records, but that refusal may result in the inability of my case manager to coordinate certain services for me. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written request to Frannie Peabody Center except where information has already been acted upon a request for the release of information.
- I can cross out any provision on this form with which I disagree
- I understand that I am entitled to a copy of this authorization, upon request. But, I do not need to review any information before it is shared.

This permission is effective for one (1) year from the date of signing, unless otherwise noted here: Optional Expiration Date (<i>Note expiration date if less than 1 year</i>): _____
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I choose to share the information listed above with this entity. I understand the information will be used only for the reason(s) listed. This information will not be shared with anyone else without my permission, unless required by law.

Client Signature (<i>if 18 yrs or older</i>)	Date	Witness Signature	Date
Signature of Legally Authorized Representative (<i>if under 18 yrs old</i>)	Date	Printed name of Authorized Representative	Relationship to Client

Acuity Scale for Provider Referrals

Frannie Peabody Center Case Management Services can assist our clients with the following areas of need. Please indicate the current level of need for each area to the best of your ability. This will enable us to assign the client to the appropriate caseload.

Area	Client identifies no needs in this area	Client identifies low needs in this area	Client identifies moderate needs in this area	Client identifies high needs in this area	Client is in crisis in this area
1. Access					
2. Housing					
3. Food/Nutrition					
4. Transportation/Home Care					
5. Education/Employment/Financial Support					
6. Treatment Adherence					
7. Dental Care					
8. Mental Health/Social Support					
9. Substance Use					
10. Relationships					
11. Legal					
12. Other					

Request for Case Management Services

Referral Source:	Date:
Is it okay for a case manager to contact you by phone and leave a message?	

Name:	DOB (if under 19 needs guardian approval):
Address:	Phone:

Referral Questions	YES	NO	Comments
I agree to meet with a case manager in the next 45 days for an eligibility screening conversation.	<input type="checkbox"/>	<input type="checkbox"/>	
Are you newly diagnosed with HIV or AIDS? (Diagnosed when? Where?)	<input type="checkbox"/>	<input type="checkbox"/>	
Are you enrolled in medical care? (Who is your provider? HIV or Primary Care?)	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on HIV medications? (How many days' supply do you currently have?)	<input type="checkbox"/>	<input type="checkbox"/>	
Are you safely housed? (Housing status details)	<input type="checkbox"/>	<input type="checkbox"/>	
Health insurance? (Who is insurer?)	<input type="checkbox"/>	<input type="checkbox"/>	
Enrolled in ADAP? If so, please include ADAP enrollment number.	<input type="checkbox"/>	<input type="checkbox"/>	
Do you currently have income? If so, what is your annual income?	<input type="checkbox"/>	<input type="checkbox"/>	

Please give us a sense of this client's level of need at this point in time. Family status? Employment status? Transportation? Language? Urgent needs?

VERIFICATION OF HIV STATUS

Patient Name: _____ Date of Birth: _____

Patient has been diagnosed with HIV (not AIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of HIV diagnosis:	
Patient has been diagnosed with AIDS, consistent with diagnostic criteria established by the US CDC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of AIDS diagnosis:	
Patient has been diagnosed with Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient has been diagnosed with Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No

 Physician's Name (please print)

 Date

 Physician's Signature

 Date

This information is necessary in order for us to serve your patient. Please return as soon as possible to:

**Frannie Peabody Center
 Attn: Case Management
 30 Danforth Street, Suite 311
 Portland, ME 04101
 Fax: (207) 879-0761**