CHOICES
Consumers Having Ownership in Creating Effective Services

1231 Gambell Street, Suite 300
Anchorage, AK 99501
Phone: (907)333-4343 | FAX (907)333-4383
Our Hours: Mon – Fri | 9AM – 5PM

INSTRUCTIONS FOR CHOICES INC. REFERRAL

Information for Referring Providers:

- A healcare practitioner referral is ***required*** for the Assertive Community Treatment Program (ACT)
- For ICM, PATH or PEER services, patients may self-refer by contacting at (907) – 333 – 4343 for a brief pre-screening interview or pick up a copy of our New Client Intake Packet from our office or our website.
- To determine if your client meets **enrollment criteria** (page 2 of this form) to any of our programs, all referrals to CHOICES, Inc. services **must** contain:
  - ❑ **The CHOICES Inc. Referral Form**, which includes reason for referral and relevant client history
  - ❑ A **Release of Information** for the client. Any additional releases for other persons or agencies should be included. Release forms can be photocopied.

Information for your patient:

- Please ensure your patient is aware that the referral is being made.
- CHOICES Inc, Intake Coordinator will make two attempts to contact the patient and leave two voicemails, when consent is provided.
  - If the patient cannot be reached, the referring provider will be notified.
- Please encourage your patients to call CHOICES, Inc. to check on the status of their referral.
- Given CHOICES, Inc. follows a peer-support model, your patient can expect to have peers involved in their care.

How to submit a referral:

1. You may fax the completed CHOICES Inc referral form to: (907) – 333 – 4383
2. You may also mail the completed CHOICES Inc referral form to:

   CHOICES, Inc
   Client Intake and Records Coordination
   Gambell Street, Suite 300
   Anchorage, AK 99501
3. *An emergency referral may be expedited on **case by case** basis by emailing the forms directly to our intake coordinator at kseniab@choices-ak.org*

- Please ensure each referral is faxed individually
- To assist in the intake & referral process, please forward a copy of the patient's face sheet, the most recent progress note detailing the reason for this referral, the most recent printed medication list with dosages, and a copy of the most recent psychiatric evaluation &/or history & physical examination will be helpful; although, they are not required for the intake consultation to be done.
  - Please note criminal justice documents are not required as part of the referral. If they are needed, the service will contact the referring provider directly

If your patient is in crisis or in need of immediate help, please direct them to the nearest emergency department or call 911

Please, review the eligibility criteria for our programs on the next page before submitting a referral

OUR PROGRAMS

The level of behavioral health care service and the type of program that may offer these services depends on the determined need. Services generally include medication stabilization, individual and group counseling, check-ins, problem solving and daily living tasks assistance, crisis intervention, and co-occurring disorder services. We also offer case management services to individuals that demonstrate the needs for this level of care.

Please, review brief description and eligibility requirements four our programs:

Assertive Community Treatment

Housing First

ACT is an integrated team-based approach designed to provide comprehensive community-based supports to help people remain stably housed. ACT team addresses the needs of clients with severe and persistent mental illness, including addictions, and may support individuals in accessing psychiatric treatment and rehabilitation. Our team consists of health care providers, social workers and peer support workers. ACT team helps clients with the most acute needs and may provide support on an ongoing basis. In some cases, individuals will need to have access to supports 24 hours a day.

ELIGIBILITY

Priority is given to those with a primary diagnosis of schizophrenia, schizoaffective disorder, other psychotic disorders or bipolar disorder. Written referral from a healthcare professional is required for enrollment in ACT.

Intensive Case Management

Recovery Coordination | Substance Abuse

Intensive Case Management (ICM) team supports individuals through a case management approach, the goal of which is to help clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. It has a moderately strong evidence base. It is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period.

ELIGIBILITY

Priority is given to those with a **history of recent treatment** for behavioral health disorders, including substance use disorders, **and** those who have specific case management needs.

Projects for Assistance in Transitioning from Homelessness

The Federal grant program Projects for Assistance in Transition from Homelessness (PATH) provides assistance to individuals who are homeless and have serious mental illnesses. PATH is an Outreach Program that engages homeless individuals with mental illness living in emergency shelters or in places not meant for human habitation in Anchorage. PATH aims to re-integrate consumers with financial, medical, psychiatric and housing services.

ELIGIBILITY

Individuals who have a serious mental illness or serious mental illness and substance abuse; and are homeless or are at imminent risk of becoming homeless.

Peer Support Services

Peer Support Services are specific rehabilitative services emphasizing the acquisition, development and enhancement of skills needed by an individual with a mental illness to move forward in their recovery. These services are self-directed and person-centered with a focus on recovery. Peer Support Services are identified in an individualized treatment plan and are characterized by a partnering approach between the certified peer specialist (CPS) and the person who receives the services.

ELIGIBILITY

Eligible clients must receive either Assertive Community Treatment, Intensive Case Management, Adult Rehabilitative Mental Health Services, or Intensive Residential Treatment Services.

If you have questions about the enclosed information, please call (907) – 333 – 4343. You may fax or mail the information to us. Thank you for your assistance and cooperation.

Sincerely,
CHOICES Inc.,
Client Intake and Records Coordination

1231 Gambell Street, Suite 300
Anchorage, AK 99501
Phone: (907)333-4343
FAX (907)333-4383

CHOICES Staff Only

Client ID:

Date Received:

Received by *(Initials)*

Method ☐ Mail ☐ Fax ☐ Email ☐ In-Person

Disposition:

☐ Enrolled ☐ Denied ☐ Waiting List

Reason for Denial:

CHOICES INC. REFERRAL FORM

Fax or mail form with copy of insurance card (front & back) and supporting provider note – in order to process.

A. CLIENT IDENTIFICATION

1. Last Name
2. First Name
3. Middle Name
4. Other Names

5. Date of Birth *(mm/dd/yyyy)* / /
6. Age *(in years)*
7. Social Security Number - -

8. Address
9. City
10. State
11. ZIP Code

12. Best Contact Number for the Client ( ) - -

Permission to leave a message ☐ Yes ☐ No

Best time to contact: ☐ AM ☐ Afternoon ☐ PM ☐ Any time

14. Gender

☐ Male ☐ Female
☐ Trans-Male ☐ Trans-Female
☐ Other ☐ Gender Non-Conforming

15. Does the client require interpretation services?

☐ Yes ☐ No *Language:*

16. Are there any accessibility concerns?

☐ Yes ☐ No *Specify:*

17. Health Insurance Coverage? ☐ Yes ☐ No 18. Insurance Agency:

19. Policy Effective Date
20. Group ID Number
21. Member ID#

B. REFERRING PROVIDER INFORMATION

1. Referral Source (Agency & Name of Staff Making Referral)

Billing Number:

2. Please select one of the following:

☐ Primary Care Physician
☐ Nurse Practitioner
☐ Mental Health Provider
☐ Other:

3. Phone Number
4. FAX:
5. Email:

6. Address *(must include)*

7. Is the client aware of this referral? ☐ Yes ☐ No

Documentation Enclosed:

☐ Face Sheet ☐ Progress Notes ☐ Insurance Card Copy
☐ Psychiatric Evaluation ☐ Medication Record ☐ Verbal Report Forms
☐ Release of Information ☐ Clinical Information ☐ Other:

Completed By: *(Signature)* *Date (DD/MM/YYYY)*

Internal Use Only (Affix Client ID or complete information below)	
Client Name	
Client Intake ID:	

C. CLINICAL INFORMATION

1. Program: ☐ HF-ACT ☐ ICM – SA ☐ ICM-RC ☐ PATH ☐ PEER

Services Requested:

☐ Community Treatment	☐ Substance Use Treatment	☐ Outpatient Counseling
☐ Symptom Management	☐ Medication Assistance	☐ Benefits Coordination
☐ Housing	☐ Activities of Daily Living Assistance	☐ Education/Employment Assistance
☐ Unknown	☐ Other:	

2. Reasons for referral/specific questions/intervention for which you are seeking input.

3. Current alcohol/substance use: *(indicate current substances, amount, frequency of use, etc.)*

4. Is the client in custody? ☐ Yes ☐ No *Expected Release Date:*

5. Is this client currently receiving Mental Health services or treatment? ☐ Yes ☐ No

6. Recent psychiatric hospitalization/emergency visit? ☐ Yes ☐ No Date:

7. Agencies, hospitals or therapies involved within the last year:

8. Diagnosis *(If known)* AXIS I: AXIS II:

D. PAST AND CURRENT PSYCHIATRIC HISTORY (Y/N)

Date of last psychiatric assessment:

	Current	Past		Current	Past
Major Depressive Disorder			Alcohol/Substance Dependence		
Bipolar Affective Disorder			Suicidal Ideation		
Anxiety Disorders			Suicidal Attempts		
Obsessive Compulsive Disorder			Self-Harm		
Post-Traumatic Stress Disorder			Aggressive Behavior		
Schizophrenia			Other Psychotic Disorders		
Eating Disorder			Other		

E. RISK AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

Risk	Yes	No	If Yes, When	Details
Suicide attempt/ideation	☐	☐		
Deliberate self-harm	☐	☐		
Violent behavior/safety concerns	☐	☐		
Legal involvement	☐	☐		
Hx of intentional property damage	☐	☐		

Affix client label

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

CHOICES, INC. OFFICE OF RECORDS AND CLIENT ADMISSIONS
1231 GAMBELL STREET SUITE 300, ANCHORAGE AK 99501 | T: (907) – 333 – 4343 | F: (907) – 333 – 4383

By completing all sections of this form, you allow CHOICES, Inc. to have access to your medical information to ensure you receive the best care possible, including any follow-up care that may be needed. To allow CHOICES, Inc. the ability to obtain from or to share your health care information with your doctor, complete and sign this form. We will only send information that pertains to your care.

Please be advised that if your health records contain information relating to Alcohol/Substance Use Information, Mental Health information or HIV/AIDS (Human Immunodeficiency Virus that causes AIDS), we require separate written authorization for release of this information.

ALL 5 SECTIONS MUST BE FULLY COMPLETED.
Incomplete forms may be returned.

SECTION 1: APPLICANT INFORMATION

Applicant Name: (Last, First, Middle)	Date of Birth (MM/DD/YYYY)

SECTION 2: INFORMATION SOURCE

I hereby authorize CHOICES, Inc. and its employees to:

☐ **Get** my health care information indicated below **FROM** **OR** ☐ **Send** my health care information indicated below **TO**

Individual/Organization

Address | **City, State, Zip**

Phone | **Fax**

To be ☐ Mailed ☐ Faxed ☐ Shared verbally only ☐ Emailed to:

SECTION 3: DESCRIPTION OF THE INFORMATION TO BE SHARED *(check only one box)*

☐ **Psychotherapy notes:** Federal law requires a separate authorization to use or release psychotherapy notes.

If you check this box, you may not check another box below.

☐ **All information** related to the provision of and payment for my health care benefits or services*

OR

☐ **Limited Information** from the following Routine Record Sets *(please check all that apply to you)*

☐ Progress Notes
☐ Consultations
☐ Discharge/Continuing Care Summary
☐ Intake/Mental Health Assessments
☐ Medical History/Physical Exam
☐ Medical and Laboratory Results
☐ Physician Orders
☐ Other (describe) ______________________
☐ Immunization Records
☐ Billing Records
☐ Psychiatric Evaluation

Dates to include: ☐ Last 6 months ☐ Last year ☐ All dates ☐ Other From: To:

Note: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for CHOICES, Inc. for any of the following information by initialing all that apply:

SENSITIVE MEDICAL INFORMATION (SUBSTANCE ABUSE, MENTAL HEALTH, HIV/AIDS):

THIS SECTION MUST BE COMPLETED

I understand what may happen if I release the following sensitive information and have indicated which items I do wish to release and/or those I do not wish to release below.

☐ **I DO** ☐ **I DO NOT** wish to release HIV/AIDS records ____ *(initial)*

☐ **I DO** ☐ **I DO NOT** wish to release Mental Health Treatment records ____ *(initial)*

☐ **I DO** ☐ **I DO NOT** wish to release Alcohol/Drug Abuse Treatment records** ____ *(initial)*

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality and regulations (42 CFR part 2) and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (this approval at any time by providing notice to CHOICES, Inc., or as described below in Part 6. I understand that I cannot cancel this approval when this form has already been used to disclose information.

I authorize the release of the Sensitive Medical Information selected above without review **UNLESS** I initial here ____

SECTION 4: REASON FOR DISCLOSURE

☐ Coordination of Care ☐ Eligibility Determination ☐ Billing or Claims ☐ Personal Use Only

☐ Legal Purposes ☐ Quality of Care Review ☐ Other (*describe*) ____

SECTION 5: DATE OF EXPIRATION OF THIS AUTHORIZATION

This authorization shall be in force and effect for

☐ One time only ☐ 3 Months ☐ 6 Months ☐ 9 Months ☐ One Year

Or until I revoke it, in the manner described below, or until ***(insert expiration date or event):***

SECTION 6: WHAT ARE YOUR RIGHTS?

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time**. But if you revoke this authorization, the revocation will not affect the disclosure of any information that CHOICES, Inc. has already sent to the recipient**.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information. Please note that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

SECTION 7: SIGNATURE

I have read this Authorization form and I understand it. By signing below, I give my permission for CHOICES, Inc. to access the Medical Information as described in this form and I release CHOICES, Inc., its employees, directors, officers and clinical staff, from legal responsibility or liability for the release of the Medical Information.

Applicant Signature	*Printed Name*	*Date*
Personal Representative Signature	*Printed Name*	*Date*