QCI Referral & Initial Paperwork
**Medicaid_Uninsured**
3/13/2019
3 Pages + ROI

**QCI STAFF**
Processed by (name)_____
Date received_____
Date of 1st appt_____

# *QCI Behavioral Health*

## Referral for Services:

**Please fill in all questions to expedite referral process.**

**Note: QCI serves individuals with Medicaid and uninsured.**

**Please indicate which County you are requesting services in:**

___Washington County ___Prince George's County ___Charles County ___Calvert County ___St. Mary's County

**Please indicate service(s) for which you are referring this individual:**

_____ Mobile Treatment Services _____ Outpatient Mental Health Services
_____ Rock-Ward Center Homeless Program

**Does the patient speak English?** ____Yes ____No *NOTE: QCI only provides services for English speaking patients at this time. QCI will attempt to point non-English speaking individuals, and those requiring sign language translation, to appropriate resources to the best of our ability.*

**Patient Name**_____ **Referral Date**__
**Address**_____ **Apt**_____
**City**_____ **State**_____ **Zip Code**_____
**Phone**_____ **DOB**_____
**SSN** _____ **Gender:** ____Female ____Male

**Race** ____American Indian/Alaskan Native ___Asian ____Black/African American
____Native Hawaiian/Other Pacific Islander ____White

**Ethnicity** ____Hispanic or Latino ____Not Hispanic or Latino **Marital Status** ____Single ____Married ____Divorced
**Smoking** ____Yes ____No If yes, how many packs/day? _____

**Is the Patient a Veteran?** ____Yes ____No ____Unknown If yes, where?_____

**Emergency Contact**_____
Relationship to patient: _____ Phone: _____

**Legal guardian name** (if applicable) _____
Relationship to patient: _____ Phone: _____

**Rep payee** (if applicable) _____
Relationship to patient: _____ Phone: _____

**Probation/Parole Officer** (if applicable): _____ Phone: _____

**Employed?** ___Yes ___No If yes, where? _____
If no, are you actively seeking employment? ___yes ___no

**Does the Patient have any type of medical insurance?**
Insurance Carrier: _____ID #: _____

**If Patient has no insurance, one of the following Grey Zone eligibility criteria must be checked:**
___Homeless ___SSDI for mental health reasons ___Received services in the public mental health system within the 2 years
___Discharged from a Maryland psychiatric hospital or residential crisis bed within the past 3 months
___Referred by order of a Conditional Release ___Released from Dept. of Corrections/prison/jail within the past 3 months

**Where is the Patient living?** _____

**Briefly describe the Patient's needs?** _____
_____
_____

**History of psychiatric hospitalizations:** ___Yes ___No If yes, please indicate facilities and dates of service:
_____
_____
_____

**Please attach discharge summary if available.**

**Current Medications(s), dosage, directions/how often, prescribed by:** _____
_____
_____

**Has Patient ever been diagnosed with Autism, Asperger's, Pervasive Developmental Disorder (PPD) or any other developmental disability?** ___Yes ___No If yes, what was the diagnosis? _____
Is Patient under a doctor's care for the above mentioned? ___Yes ___No If yes, where_____

**Is the Patient a hurricane victim?** ___Yes ___No If yes, which storm_____

**Mental Health Diagnosis** (if known): _____
_____
_____
Recent Assessment Measures (optional): _____

**Social/Environmental/Physical Health Issues:** _____

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**History of court charges and incarcerations** (check where applicable):
_____Drug-Related _____Theft _____Assault _____Weapons Possession _____Sexual* _____Other
*Is patient currently registered as a sex offender? _____yes _____no
Number of arrests in the past 90 days: _____

**Additional Contacts:**
Physician: _____ Phone: _____
Case Manager: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Therapist: _____ Phone: _____

**Referral source:**
Is this a self-referral? ___Yes ___No If no, please complete the following information and attach a signed release so that we may contact you for follow-up if needed.

If patient is being discharged from the hospital, please send patient's records upon release.
Contact: _____ Phone: _____
Hospital: _____

If patient is being referred by another organization:
Contact: _____ Phone: _____
Organization: _____ Relation to Patient: _____

**Patient Agreement:**
I wish to be considered for services with QCI Behavioral Health.
Patient Signature: _____ Date: _____

**Transportation**
___ Patient needs transportation If yes, are special accommodations needed? ___yes ___no
___ Patient does not need transportation

Client applied for (check all that apply): ___Medical Assistance ___SSI/SSDI

- **Please include copy of most recent:**
  - **Discharge summary**
  - **Physical exam**
  - **Results of any diagnostic testing including EKG and labs**
  - **List of current medications including any long-acting injections given**

- **Patients should bring to their first visit:**
  - **ID**
  - **Social Security card**
  - **Birth certificate**
  - **Proof of income**
  - **Health insurance card**
  - **If ID does not have a Maryland address, please bring proof of Maryland residency:**
    - **Utility bill or Lease**
  - **If the patient is a minor, please bring immunization records.**

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# *QCI Behavioral Health*

## Authorization to Disclose Health Information/Release of Information

Patient Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ DOB: _____

I authorize the use or disclosure of the above named individual's health information as described below:

A. The following individual or organization is authorized to:

_____release the information _____receive and use the information

Individual/Organization Name: _____

Address: _____

Phone: _____ Fax: _____

B. The following individual or organization is authorized to:

_____release the information _____receive and use the information

Individual Name/Organization Name: QCI Behavioral Health, LLC

| | | |
|---|---|---|
| 9475 Lottsford Road, Suite 250<br>Largo, MD 20774<br>Ph: 301-636-6504<br>Fax: 301-636-6509 | 5010 Regency Place, Suite 203<br>White Plains, MD 20695<br>Ph: 240-427-3554<br>Fax: 240-419-2556 | 201 North Burhans Boulevard<br>Hagerstown, MD 21740<br>Ph: 301-791-0032<br>Fax: 301-797-4760 |

C. The purpose(s) for which the information may be released:

_____At the request of the patient _____Continuation of care/consultation

_____Social Security/Disability Certification

_____To pass on message to the patient; determine the patient's location

_____To exchange information concerning the patient illness and treatment

_____Other: _____

D. If not previously revoked, this authorization will terminate on the earliest of the following dates:
One year from the signatures date below, or upon the following date, event, or condition:
_____
(For authorizations to terminate due to an event or condition, the parties authorized to release information above must be notified in writing upon occurrence of the event or condition to cancel authorization.)

**What information** is being released:
Items below may include information on substance abuse and HIV/AIDS status unless indicated otherwise here:

_____Do not disclose substance abuse information _____Do note disclose HIV information

_____Emergency Room Record _____Entire record except psychotherapy notes

_____Most Recent History and Physical _____Referral _____Immunization Record

_____Intake Interview _____Medication List _____Psychiatric Evaluation/Diagnosis

_____Discharge Summary _____Psychological/Educational Report _____History of Allergies

_____Psychosocial Assessment _____Pathology Report _____Verbal Communication

_____Diagnostic Test/Results (labs, x-rays, and other test results) _____Most Recent Physical Exam

_____Other: _____

_____Psychotherapy Notes (Due to the highly sensitive nature of psychotherapy notes federal law requires a separate authorization form for their disclosure.)

E. **Dates of information** (it applicable): From: _____ to _____

F. **In understand the following:**
A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. **Revocation:** I have the right to revoke this authorization at any time. If I choose to cancel the release of information/authorization, I must notify the person/company identified in Section B in writing that I revoke this authorization. The revocation will not apply to information that has already been released in response to this authorization. **Re-disclosure:** If this information is to be received by individuals or organizations that are not health care providers, health care clearing houses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed and no longer protected by federal privacy regulations. Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws. **Conditioning of eligibility:** QCI Behavioral Health will not withhold treatment from me if I refuse to sign this form.

G. **Signature: _____Date: _____**
Patient, Parent, Legal Guardian

Authorizations signed by a legal representative must include a copy of the Guardianship papers or a Power of Attorney.

Witness (if client is unable to sign):
Signature: _____Date: _____