CATHOLIC CHARITIES OF CORTLAND COUNTY
MRT/ PERMANENT SUPPORTIVE HOUSING REFERRAL FORM

REFERRAL SOURCE
Referring Agency, if applicable: _____

Contact Name: _____ Referral Source Phone: _____

Referral Source E-mail: _____ Admission Date: _____

QHP Signature: _____ Anticipated Discharge Date: _____

APPLICANT INFORMATION:
Name: _____ Phone: _____

Address: _____

Current living situation: _____

Social Security Number: _____ Date of Birth: _____

☐Female ☐ Male ☐ Non-Binary ☐Transgender

Has the applicant been referred to us before? ☐ No ☐Yes
If yes, please provide the details:

FINANCIAL INFORMATION:
Medicaid Number: _____ County of Origin: _____

Medicaid MCO: _____ Public Assistance Amount: _____

Private Insurance Company: _____ SSI/SSD Amount: _____

Unemployment Amount: _____

Other income: _____

Is the applicant currently sanctioned by DSS? ☐ No ☐Yes

If yes, please provide details:

MEDICAL HISTORY:
The applicant has the following medical conditions:

Allergies; details:

Seizures; details:

HEALTH SERVICE USE:
Have you been in inpatient hospitalization 1 or more times in the past 12 months?
☐ Yes ☐ No If yes, how many?

Have you had 4 or more emergency room visits in the past 12 months?
☐ Yes ☐ No If yes, how many?

** Referring agency should provide any supporting documentation that is available to support the above episodes**

BEHAVIORAL HEALTH ***(Substance Use and/or Mental Health)***

Principal Diagnosis ICD Code

_____ _____

The applicant has the following additional behavioral health conditions.
(*Please include all substance use and mental health information)*

Date of most recent psychosocial assessment: _____

Please attach psychosocial assessment to this completed referral.

Is the applicant capable of self-preservation (evacuation of apartment) in case of an emergency?

☐No ☐Yes

Is the applicant capable of self-administration of medications?

☐No ☐Yes

Recommendation(s) regarding treatment focus and why you, as the referral source, feel this level of care may be appropriate for the applicant.

JUSTICE INVOLVEMENT

Probation

☐ Never

☐ Current

Probation Officer Name & Contact

_____

Parole

☐ Never

☐ Current

Parole Officer Name & Contact

_____

Include the following with this completed referral:

- Referrals made by a clinical professional must include a QHP signature.
- Current Medication List
- Current Psychosocial Assessment
- Documentation supporting inpatient, hospitalizations, and Emergency Room Visits, if any.
- Signed Release

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

Fax: 607-756-5992

Mail:

Catholic Charities
ATTN: Community Housing Program Manager
33-35 Central Avenue
Cortland, New York 13045

AUTHORIZATION FOR RELEASE OF INFORMATION	**Client's Name (Last, First, M.I.)**	**Medicaid Number**
	Sex	**Date of Birth**
	Agency Name: Catholic Charities of Cortland County	**Unit/Ward:** Community Housing

This authorization must be completed by the client or their personal representative to use/disclose protected health information (for other than 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.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

- ☐ Contact Information
- ☐ Current Medications
- ☐ Current Services
- ☐ Daily Living Skills
- ☐ Diagnosis
- ☐ Education
- ☐ Entitlements
- ☐ Emergency Contact Info.
- ☐ Functional Abilities
- ☐ Mental Health Status
- ☐ Psychosocial information
- ☐ Characteristics/ Photograph
- ☐ Electronic Files
- ☐ Other: _____

Purpose or Need for Information:

1. This information is being requested:
   - ☐ by the individual or his/her personal representative; or
   - ☒ Other (please describe) Catholic Charities (Cortland County)
2. The purpose of the disclosure is (please describe)

- ☐ Screening/Assessment
- ☐ Bill Insurance
- ☐ Emergency Contact
- ☐ Emergency Services
- ☐ Establish Entitlements
- ☐ Establish Services
- ☐ Housing
- ☐ Coordinating Services
- ☐ Electronic Database
- ☐ Other: _____

Exchange of Information, in either direction, between the parties below
(Include: Name, Address, Title of person/Organization/Facility/Program)

Catholic Charities of Cortland County Community Housing Programs 33-35 Central Avenue Cortland, New York 13045 Phone: (607) 756-5992 Fax: (607) 756-5999	(Two Way) ⇔	Admissions Committee: Including Representatives from Family & Children's Counseling Services, Cortland County Mental Health Clinic, Cortland City Police Department, Guthrie Cortland Medical Center, Cortland County Probation Department

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities shown below. 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 taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

B-1. **One-Time Use/Disclosure**: I hereby permit the one-time use or disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above.

My authorization will expire:

- ☐ When acted upon;
- ☐ 90 Days from this Date;
- ☐ Other:

Agency Name	**Client's Name (Last, First, M.I.)**	**Medicaid Number**
Catholic Charities (Cortland County)		

B-2. Periodic Use/Disclosure**:** I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☒ When I am no longer receiving services from: Catholic Charities of Cortland County

☐ One year from this date ☐ Other: _____

C. **Client Signature**: I certify that I authorize the use of my health information as set forth in this document.

Signature of Client or Personal Representative Date

Client's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Client (*required if Personal Representative signs Authorization)*

D. **Witness Statement/Signature**: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the client and/or the client's personal representative.

WITNESSED BY: _____

Staff person's name and title

Authorization Provided to: _____

Date: _____

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information

Title Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

Signature of Client or Personal Representative Date

Client's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act for the Client *(required if Personal Representative signs Revocation of Authorization)*