Catholic Charities of Cortland County

CARING FOR OUR COMMUNITY ONE PERSON AT A TIME

Peer Support Referral

Date: _____

Please Fax Referral and Signed Consent to: (607) 756-5999

Client Information

Name: _____ Date of Birth: _____ SSN: _____

Best Phone: _____ Email: _____

Address: _____

Emergency Contact Name: _____ Emergency Contact Phone/Email: _____

Medicaid #: _____
(Format: AA12345B)

Referring Provider

Referral Agency: _____

Contact Name: _____

Phone: _____ Email: _____

Medical & Behavioral Health

	Concerns/Diagnosis/Treatment	Providers	Needs / Upcoming Appointments
Physical			
Mental			
Substance Use			
Other			

How can we help? Indicate any area(s) of current needs/interest.

☐ Education/Vocational/Employment
☐ Financial Support
☐ Health Care

☐ Advocacy
☐ Life Skills
(Budgeting, organization, communication, etc.)
☐ Narcan Education/Training

Other: _____

☐ Mental Health Counseling/Treatment
☐ Social Support
☐ Substance Use Counseling/Treatment

☐ Peer Socialization
(Social supports)
☐ Peer Support
(Peer mentoring, bridging to services, empowerment, etc.)

PEER SERVICES

Client Name: _____

Financial

Do you work with someone at DSS? ☐ No ☐Yes; Caseworker Name: _____

Public Assistance: ☐TANF ☐ SNAP ☐HEAP

Other income: (e.g. SSI/Disability/Veterans): _____

Education

☐HS Diploma / GED
☐College ☐Vocational

Employment

☐Employed ☐Unemployed ☐Self-employed

Housing

☐ Currently unhoused
Do you have a DSS housing voucher? ☐ Yes ☐ No
Where are you staying at this time? _____

☐ Currently housed
Do you feel safe at home?
Do you live:
☐ Alone ☐ With friends/family ☐ Temporary Housing ☐ Residential Program
☐ Other _____

Supports

☐ Family or Friends ☐Support groups
☐ Counseling/Treatment ☐Other _____
☐ Other Agency Services

Please send complete referral, including release of information via one of the following methods:

By Mail:
Catholic Charities of Cortland County
33-35 Central Avenue
Cortland, New York 13045
Attn: Desiree Richmond

By Secure E-mail: drichmond@ccocc.org

By Fax: (607) 756-5999

For questions or assistance, please call (607) 756-5992, ext. 171

Catholic Charities of Cortland County

CARING FOR OUR COMMUNITY ONE PERSON AT A TIME

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name (Last, First, M.I.) Medicaid CIN:

Date of Birth _____ Program Name: Peer Services

Facility Name: Catholic Charities of Cortland County

This authorization must be completed by the client or his/her 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
☐ : _____

Info can be disclosed:
☒ Verbal
☒ Written

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 of Cortland County
2. The purpose of the disclosure is (please describe)

☐ Assessment ☐ Bill Insurance ☐ Emergency Contact ☐ Emergency Services
☐ Establish Entitlements ☐ Establish Services ☐ Housing ☐ Skill Development
☐ Treatment Coordination
☐ OTHER: _____

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

Catholic Charities of Cortland County Peer Support Services 33-35 Central Avenue Cortland, New York 13045 Phone: (607) 756-5992 Fax: (607) 756-5999	**Organization Name**: **Address**: **Phone**: **Fax**:

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 services from the Catholic Charities of Cortland County, 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).

Facility/Agency Name	Client's Name (Last, First, M.I.)
Catholic Charities of Cortland County	

B. 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 offered and/or provided to the client and/or the client's personal representative.

WITNESSED BY: _____

Staff person's name and title

Authorization Provided to: _____

Date: _____

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)*