**CONNECT PROGRAM 2020-2021**

SCOTT COUNTY MENTAL HEALTH

REFERRAL AND PERMISSION FOR SCREENING AND FOLLOW-UP

CLIENT INSURANCE INFORMATION AND RELEASE OF INFORMATION

STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ School & Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Okay to Leave Messages? Yes \_\_\_\_\_ No \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City St. Zip

Guardian email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source (please check) Teacher \_\_\_\_\_ Parent \_\_\_\_\_ Student \_\_\_\_\_

 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of service requesting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral/Concerns:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does the student have health insurance coverage? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

*(Please contact our insurance eligibility specialist at 952-496-8624 if you have questions regarding coverage, deductibles and copay/coinsurance)*

**INSURANCE PROVIDER**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Health Savings Account? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you need help paying for Mental Health Services, please check this box*

*to have the eligibility specialist contact you for assistance.* [ ]

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my consent for the student, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 *Parent/Legal Guardian Name Student Name*

to have a Mental Health screening and referral, as needed. I also give permission for individual or group therapy if it is recommended by the Mental Health Specialist. I understand that relevant Mental Health information and report(s) will be shared with appropriate school staff, as well as the Mental Health Specialist’s treatment team and supervisors at the Scott County Mental Health Center.

Client Rights, Informed Consent, and Required Reporting

Information gathered from you or your student during an interview or therapy session is generally classified as “private” and is not shared unless you 1) have given written permission to disclose information 2) the Minnesota Department of Human Services needs to review files to monitor clinic policies or Medical Assistance records 3) we receive a valid court order or 4) your student indicates that they are planning to harm themselves or someone else. We are also required to file reports to the appropriate state agency when we learn of children or “vulnerable adults” (those over 18 who live in, or receive services from a state agency or are otherwise unable to report without assistance) who are currently, or have within a specified period of time, been abused or neglected.

“Abuse” is defined as any act that violates the prostitution or criminal sexual conduct laws; or the intentional and nontherapeutic inflicting of pain or injury; or a persistent course of conduct intended to produce mental or emotional distress. “Neglect” happens when someone supposed to take care of a minor or a vulnerable adult fails to supply or ensure that a person has necessary food, clothing, shelter, health care, or supervision.

Minors (children under age 18), have a legal right to request that information be kept from their parents. This request needs to be in writing and it should explain the reasons for withholding information from parents and show that the minor understands the consequences of doing so. In a few cases, the law permits us to withhold information from parents without a request from the minor, if the information concerns the treatment of drug abuse, or venereal disease, or if the minor is married.

In addition, you may access copies of your child’s records from your therapist and you have to right to challenge the information and insert your own objection or explanation. Clients also may voice questions, complaints, or grievances and are encouraged to discuss these with their therapist or the Director of the Mental Health Center. If you have any questions regarding these areas, please consult with your child’s therapist. As a part of the Connect Program, we will from time to time develop grouped statistics and other anonymous information that does not identify you or your child in any way.

**Billing Authorization**

To the best of my knowledge, the insurance information I have provided is accurate and complete. I understand that if my financial and/or insurance situation changes, it is my responsibility to notify the office of the new information. I hereby authorize a representative of the Scott County Human Services Department to contact my insurance company(ies), if necessary, to verify eligibility and benefit information. I further authorize Scott County Human Services to release information in connection with my child’s treatment (such as diagnosis and dates of service) to third-party payers or others for purposes of billing or obtaining payment. I hereby assign payment for the services my child receives from Scott County professionals be paid directly to Scott county Human Services Department. I request that this authorization remain in effect until expressly revoked by me. A photocopy of this authorization is as valid as the original.

By signing below, I acknowledge that I am familiar with the policies stated above and have given my consent for billing to take place in accordance with these policies.

***If client is a minor, by signing below, I indicate that I have legal authority to request treatment for this client and have verified that the above information is accurate.***

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 *Parent/Legal Guardian Signature Date*

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*Student Signature Date*

