Purpose:

The Department of Mental Health (DMH) seeks to facilitate independence and recovery by providing services and supports to children, youth and families with serious emotional disturbance and to adult individuals with serious and persistent mental illness.

How to Request DMH Service(s):

Individuals who request mental health services through DMH must submit the following forms. It is essential that **signatures and dates** be included where indicated on each form:

- ☐ *Request for DMH Services* application. (see pages 5 – 9)
- ☐ Signed *DMH Service Authorization Determination* (see page 10)
- ☐ Signed *Authorization(s) for Release of Information* (see pages 11 & 12)

The following information is needed to make a decision within the regulatory time frames. It is strongly recommended that clinical information be submitted at the time of the application to expedite the determination process. If you aren't including clinical documentation, please include a signed release of information for current providers including any hospitals where you may have received treatment. Such information includes:

- ☐ Outpatient psychiatric records and testing.
- ☐ Admission and discharge reports or summaries.
- ☐ Assessments (e.g., Psychiatric and Psychosocial).
- ☐ Neuropsychological testing
- ☐ Treatment Plans
- ☐ *Individualized Educational Plan* (*IEP*) if one is in place.

DMH may require additional clinical information as necessary.

What To Expect After an Application is Submitted:

Within seven (7) days of receipt of a *Request for DMH Services* application, DMH will contact the applicant or guardian to acknowledge receipt of the *Request for DMH Services* application.

A DMH *Clinical Service Authorization Specialist* may require, as necessary, a face-to-face meeting with the applicant and/or guardian to further discuss and assess the needs of the applicant and/or the family.

If an individual is found to meet the clinical criteria for services, the Area Director or designee must determine whether the individual needs DMH services. Since the availability of DMH services is limited, DMH must prioritize to whom and how those services are provided. DMH regulations establish the criteria used to determine who is authorized to receive DMH services, and how those services are assigned.

The DMH Area Director or designee will make decisions regarding service requests upon receiving and reviewing information in accordance with DMH regulations: **http://www.mass.gov/eohhs/docs/dmh/regs/reg-104cmr29.pdf.**

The time needed to make a determination may vary based on the availability of supporting documentation. A decision will be made within 90 days of DMH receiving the application, based upon the information that is available.

Where to find Applications and *Authorizations for Release of Information* forms:

The *Request for DMH Services Applications* and *Authorization for Release of Information* are available in the DMH Area and Site Offices, acute inpatient psychiatric facilities, and in many community programs throughout the Commonwealth. They are also available from the DMH website at **http://www.mass.gov/eohhs/gov/departments/dmh/service-application-forms-and-appeal-guidelines.html**

DMH can provide interpreter and document translation services so the applicant or guardian can use their preferred language to communicate with DMH.

Where to send the *Request for DMH Services*:

Please find the applicant's city or town in the list that appears on the following pages, and send the application to the respective DMH Office from the lists below. Please call the number listed if there are any questions.

A **signed** and **dated** *Request for DMH Services* application, and **properly signed** *Authorization for Release of Information* forms must be delivered, mailed, faxed, or scanned and e-mailed to the DMH Area or Site Office with responsibility for the community where the applicant, parent or legal guardian resides at the time of application.

If you need assistance with completing the *Request for DMH Services* please contact the office below that serves the town in which the applicant lives.

Office	Mailing Address	Phone Number	Fax Number
Boston	85 East Newton Street, Boston, MA 02118	(617) 626-9200	(617) 626-9216
Brockton	165 Quincy Street, Brockton, MA 02302	(508) 897-2000	(508) 897-2047
Northampton	1 Prince Street, Northampton, MA 01060	(413) 587-6200	(413) 587-6240
Tewksbury	P.O. Box 387, Tewksbury, MA 01876-0387	(978) 863-5000	(978) 863-5091
Worcester	361 Plantation St. Worcester, MA 01605	(774) 420-3140	(774) 420-3165

Applications should NOT be sent to the DMH Central Office on Staniford Street in Boston. Doing so will result in misdirected applications, and may cause delays in the decision process.

Race and Ethnicity Categories:

Race and Ethnicity information is requested so that DMH may better provide person-centered services that are culturally and linguistically appropriate. It also helps the Department comply with regulations and standards, and allows for the planning of unmet service needs. **Providing information about Race and Ethnicity is optional**. The decision to do so, or not, will not affect the application for DMH services.

The following options may be used to complete the Race and Ethnicity sections on the *Request for DMH Services*. In filling out the application, persons who are of more than one race or ethnicity are invited to identify as such.

The racial categories listed below are based on a standard set by the federal government. Ethnicity is defined as the group of people who are connected by a common national origin, history, ancestry, language or customs and cultural experiences. The following list is provided to show some examples of ethnicities or ethnic groups, and is not meant to be a complete listing.

Race Options
American Indian/Alaska Native
Asian
Black/African American
Black/Hispanic
Chooses Not To Self-Identify
Native Hawaiian or other Pacific Islander
Other
Two or More Races
Unknown
White/Hispanic
White/Non-Hispanic

Ethnicity Examples		
Albanian	Greek	Pakistani
American - USA	Guatemalan	Peruvian
Armenian	Haitian	Panamanian
Bhutanese	Hispanic, Other	Polish
Bosnian	Hmong	Portuguese
Brazilian	Honduran	Puerto Rican
Burmese	Indian	Russian
Cambodian	Iranian	Salvadoran
Canadian	Iraqi	Somali
Cape Verdean	Irish	Thai
Chinese	Israeli	Tibetan
Colombian	Italian	Ukrainian
Congolese	Japanese	Unknown
Costa Rican	Korean	Venezuelan
Dominican	Laotian	Vietnamese
Egyptian	Lebanese	West Indian/Caribbean
Eritrean	Mexican	
Ethiopian	Moroccan	Two or More Ethnicities
Filipino	Nigerian	Other
French	Nicaraguan	Chooses Not To Self-Identify

City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH
Abington	Brockton	Boston - Hyde Park	Boston	Danvers	Tewksbury	Hadley	Northampton
Acton	Tewksbury	Boston-Jamaica Plain	Boston	Dartmouth	Brockton	Halifax	Brockton
Acushnet	Brockton	Boston - Mattapan	Boston	Dedham	Worcester	Hamilton	Tewksbury
Adams	Northampton	Boston - North End	Boston	Deerfield	Northampton	Hampden	Northampton
Agawam	Northampton	Boston - Revere	Boston	Dennis	Brockton	Hancock	Northampton
Alford	Northampton	Boston - Roslindale	Boston	Dennisport	Brockton	Hanover	Brockton
Allston	Boston	Boston - Roxbury	Boston	Dighton	Brockton	Hanson	Brockton
Amesbury	Tewksbury	Boston - Somerville	Boston	Dorchester	Boston	Hardwick	Worcester
Amherst	Northampton	Boston - South End	Boston	Douglas	Worcester	Harvard	Worcester
Andover	Tewksbury	Boston - Southie	Boston	Dover	Worcester	Harwich	Brockton
Aquinnah	Brockton	Boston – W. Roxbury	Boston	Dracut	Tewksbury	Harwichport	Brockton
Arlington	Tewksbury	Boston - Winthrop	Boston	Dudley	Worcester	Hatfield	Northampton
Ashburnham	Worcester	Bourne	Brockton	Dunstable	Tewksbury	Haverhill	Tewksbury
Ashby	Worcester	Boxborough	Tewksbury	Duxbury	Brockton	Hawley	Northampton
Ashfield	Northampton	Boxford	Tewksbury	East Boston	Boston	Heath	Northampton
Ashland	Worcester	Boylston	Worcester	E. Bridgewater	Brockton	Hingham	Brockton
Assonet	Brockton	Bradford	Tewksbury	East Brookfield	Worcester	Hinsdale	Northampton
Athol	Northampton	Braintree	Brockton	E. Longmeadow	Northampton	Holbrook	Brockton
Attleboro	Brockton	Brewster	Brockton	East Sandwich	Brockton	Holden	Worcester
Auburn	Worcester	Bridgewater	Brockton	Eastham	Brockton	Holland	Worcester
Avon	Brockton	Brighton	Boston	Easthampton	Northampton	Holliston	Worcester
Ayer	Worcester	Brimfield	Worcester	Easton	Brockton	Holyoke	Northampton
Back Bay	Boston	Brockton	Brockton	Edgartown	Brockton	Hopedale	Worcester
Baldwinville	Worcester	Brookfield	Worcester	Egremont	Northampton	Hopkinton	Worcester
Barnstable	Brockton	Brookline	Boston	Erving	Northampton	Hubbardston	Worcester
Barre	Worcester	Buckland	Northampton	Essex	Tewksbury	Hudson	Worcester
Beacon Hill	Boston	Burlington	Tewksbury	Everett	Tewksbury	Hull	Brockton
Becket	Northampton	Buzzards Bay	Brockton	Fairhaven	Brockton	Huntington	Northampton
Bedford	Tewksbury	Byfield	Tewksbury	Fall River	Brockton	Hyannis	Brockton
Belchertown	Northampton	Cambridge	Boston	Falmouth	Brockton	Hyde Park	Boston
Bellingham	Worcester	Canton	Worcester	Fenway	Boston	Ipswich	Tewksbury
Belmont	Tewksbury	Carlisle	Tewksbury	Fiskdale	Worcester	Jamaica Plain	Boston
Berkeley	Brockton	Carver	Brockton	Fitchburg	Worcester	Jefferson	Worcester
Berlin	Worcester	Charlemont	Northampton	Florida	Northampton	Kingston	Brockton
Bernardston	Northampton	Charlestown	Boston	Foxborough	Worcester	Lakeville	Brockton
Beverly	Tewksbury	Charlton	Worcester	Framingham	Worcester	Lancaster	Worcester
Billerica	Tewksbury	Chatham	Brockton	Franklin	Worcester	Lanesborough	Northampton
Blackstone	Worcester	Chelmsford	Tewksbury	Freetown	Brockton	Lawrence	Tewksbury
Blandford	Northampton	Chelsea	Boston	Gardner	Worcester	Lee	Northampton
Bolton	Worcester	Cherry Valley	Worcester	Gay Head	Brockton	Leicester	Worcester
Bondsville	Northampton	Cheshire	Northampton	Georgetown	Tewksbury	Lenox	Northampton
Boston - Allston	Boston	Chester	Northampton	Gilbertville	Worcester	Leominster	Worcester
Boston - Back Bay	Boston	Chesterfield	Northampton	Gill	Northampton	Leverett	Northampton
Boston - Beacon Hill	Boston	Chicopee	Northampton	Gloucester	Tewksbury	Lexington	Tewksbury
Boston - Brighton	Boston	Chilmark	Brockton	Goshen	Northampton	Leyden	Northampton
Boston - Brookline	Boston	Clarksburg	Northampton	Gosnold	Brockton	Lincoln	Tewksbury
Boston - Cambridge	Boston	Clinton	Worcester	Grafton	Worcester	Linwood	Worcester
Boston-Charlestown	Boston	Cohasset	Brockton	Granby	Northampton	Littleton	Tewksbury
Boston - Chelsea	Boston	Colrain	Northampton	Granville	Northampton	Longmeadow	Northampton
Boston - Chinatown	Boston	Concord	Tewksbury	Great Barrington	Northampton	Lowell	Tewksbury
Boston - Dorchester	Boston	Conway	Northampton	Green Harbor	Brockton	Ludlow	Northampton
Boston - Downtown	Boston	Cotuit	Brockton	Greenfield	Northampton	Lunenburg	Worcester
Boston - East	Boston	Cummington	Northampton	Groton	Worcester	Lynn	Tewksbury
Boston - Fenway	Boston	Dalton	Northampton	Groveland	Tewksbury	Lynnfield	Tewksbury

City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH
Malden	Tewksbury	North Truro	Brockton	Sandisfield	Northampton	Wales	Worcester
Manchester	Tewksbury	Northampton	Northampton	Sandwich	Brockton	Walpole	Worcester
Manomet	Brockton	Northborough	Worcester	Saugus	Tewksbury	Waltham	Tewksbury
Mansfield	Brockton	Northbridge	Worcester	Savoy	Northampton	Ware	Northampton
Marblehead	Tewksbury	Northfield	Northampton	Scituate	Brockton	Wareham	Brockton
Marion	Brockton	Norton	Brockton	Seekonk	Brockton	Warren	Worcester
Marlborough	Worcester	Norwell	Brockton	Sharon	Worcester	Warwick	Northampton
Marshfield	Brockton	Norwood	Worcester	Sheffield	Northampton	Washington	Northampton
Marston Mills	Brockton	Oak Bluffs	Brockton	Shelburne	Northampton	Watertown	Tewksbury
Martha's Vineyard	Brockton	Oakham	Worcester	Sherborn	Worcester	Wayland	Worcester
Mashpee	Brockton	Onset	Brockton	Shirley	Worcester	Webster	Worcester
Mattapan	Boston	Orange	Northampton	Shrewsbury	Worcester	Wellesley	Worcester
Mattapoisett	Brockton	Orleans	Brockton	Shutesbury	Northampton	Wellfleet	Brockton
Maynard	Tewksbury	Osterville	Brockton	Somerset	Brockton	Wendell	Northampton
Medfield	Worcester	Otis	Northampton	Somerville	Boston	Wenham	Tewksbury
Medford	Tewksbury	Oxford	Worcester	South Boston	Boston	West Barnstable	Brockton
Medway	Worcester	Palmer	Northampton	South Hadley	Northampton	West Boylston	Worcester
Melrose	Tewksbury	Paxton	Worcester	South Wellfleet	Brockton	West Bridgewater	Brockton
Mendon	Worcester	Peabody	Tewksbury	South Yarmouth	Brockton	West Brookfield	Worcester
Merrimac	Tewksbury	Pelham	Northampton	Southampton	Northampton	West Newbury	Tewksbury
Methuen	Tewksbury	Pembroke	Brockton	Southborough	Worcester	West Roxbury	Boston
Middleborough	Brockton	Pepperell	Worcester	Southbridge	Worcester	West Springfield	Northampton
Middlefield	Northampton	Peru	Northampton	Southwick	Northampton	West Stockbridge	Northampton
Middleton	Tewksbury	Petersham	Northampton	Spencer	Worcester	West Tisbury	Brockton
Milford	Worcester	Phillipston	Northampton	Springfield	Northampton	West Yarmouth	Brockton
Millbury	Worcester	Pittsfield	Northampton	Sterling	Worcester	Westborough	Worcester
Millers Falls	Northampton	Plainfield	Northampton	Stockbridge	Northampton	Westfield	Northampton
Millis	Worcester	Plainville	Worcester	Stoneham	Tewksbury	Westford	Tewksbury
Millville	Worcester	Plymouth	Brockton	Stoughton	Brockton	Westhampton	Northampton
Milton	Brockton	Plympton	Brockton	Stow	Tewksbury	Westminster	Worcester
Monroe	Northampton	Pocasset	Brockton	Sturbridge	Worcester	Weston	Worcester
Monson	Northampton	Princeton	Worcester	Sudbury	Worcester	Westport	Brockton
Montague	Northampton	Provincetown	Brockton	Sunderland	Northampton	Westwood	Worcester
Monterey	Northampton	Quincy	Brockton	Sutton	Worcester	Weymouth	Brockton
Montgomery	Northampton	Randolph	Brockton	Swampscott	Tewksbury	Whately	Northampton
Mt Washington	Northampton	Raynham	Brockton	Swansea	Brockton	White Horse Bch	Brockton
Nahant	Tewksbury	Reading	Tewksbury	Taunton	Brockton	Whitinsville	Worcester
Nantucket	Brockton	Rehoboth	Brockton	Teaticket	Brockton	Whitman	Brockton
Natick	Worcester	Revere	Boston	Templeton	Worcester	Wilbraham	Northampton
Needham	Worcester	Richmond	Northampton	Tewksbury	Tewksbury	Williamsburg	Northampton
New Ashford	Northampton	Rochdale	Worcester	Thorndike	Northampton	Williamstown	Northampton
New Bedford	Brockton	Rochester	Brockton	Three Rivers	Northampton	Wilmington	Tewksbury
New Braintree	Worcester	Rockland	Brockton	Tisbury	Brockton	Winchendon	Worcester
New Marlborough	Northampton	Rockport	Tewksbury	Tolland	Northampton	Winchester	Tewksbury
New Salem	Northampton	Roslindale	Boston	Topsfield	Tewksbury	Windsor	Northampton
Newbury	Tewksbury	Rowe	Northampton	Townsend	Worcester	Winthrop	Boston
Newburyport	Tewksbury	Rowley	Tewksbury	Truro	Brockton	Woburn	Tewksbury
Newton	Worcester	Roxbury	Boston	Turners Falls	Northampton	Wollaston	Brockton
Norfolk	Worcester	Royalston	Northampton	Tyngsborough	Tewksbury	Woods Hole	Brockton
North Adams	Northampton	Russell	Northampton	Tyringham	Northampton	Worcester	Worcester
North Andover	Tewksbury	Rutland	Worcester	Upton	Worcester	Worthington	Northampton
North Attleboro	Brockton	Sagamore	Brockton	Uxbridge	Worcester	Wrentham	Worcester
North Brookfield	Worcester	Salem	Tewksbury	Vineyard Haven	Brockton	Yarmouth	Brockton
North Reading	Tewksbury	Salisbury	Tewksbury	Wakefield	Tewksbury	Yarmouthport	Brockton

Applicant Legal Name _____ **SSN** _____
(Last) (First) (Middle) (Social Security Number)

Applicant Preferred Name *(If different than legal name)* _____
(Last) (First) (Middle)

Address *(Or last known address if applicant is homeless):*

_____
(Number and Street) (Apt No) (City) (State) (Zip Code)

Mailing Address *(if different than address above)*

_____
(Number and Street) (Apt No) (City) (State) (Zip Code)

Birthdate ____/____/____ **Age** _____ **Gender** _____ **Marital Status** _____
MM DD YYYY

Race _____ **Ethnicity**_____ **Preferred Language** _____
(Optional) (Optional)

Are interpreter services needed?	☐ Yes	☐ No	
➢ If yes, who needs an interpreter?	☐ Applicant	☐ Parent	☐ Guardian
Is applicant deaf or hard of hearing?	☐ Yes	☐ No	
Is applicant legally blind *(vision <20/200 or totally blind)*?	☐ Yes	☐ No	
If 18 or older, is applicant a registered voter (*optional*):	☐ Yes	☐ No	☐ Unknown
Has applicant served in the military?	☐ Yes	☐ No	☐ Unknown

(Please check all that apply below, and provide phone number/e-mail address)

☐ Day/Work Phone ( ) _____ May we leave a message? ☐ Yes ☐ No
☐ Evening Phone ( ) _____ May we leave a message? ☐ Yes ☐ No
☐ Cell Phone ( ) _____ May we leave a message? ☐ Yes ☐ No
☐ e-mail _____ May we leave a message? ☐ Yes ☐ No

Was applicant adopted, or in the adoption process? ☐ Yes ☐ No ☐ Unknown

Parent/Guardian Preferred Language *(if applicant is under 18)*: _____

If applicant is under age 18, who has **legal** custody? ☐ Parent ☐ DCF ☐ Court Appointed ☐ Self *(emancipated)*

If applicant is under age 18, who has **physical** custody? ☐ Parent ☐ DCF ☐ DYS ☐ Self *(emancipated)*

Additional Contact Information *(Please Include a Release of Information for each person listed)*

Name of Emergency Contact _____

Relationship to applicant: _____ Phone # _____

Address: _____

Parent/Agency Contact (1) _____

Relationship to applicant: _____ Phone # _____

Address: _____

Parent/Agency Contact (2) _____

Relationship to applicant: _____ Phone # _____

Address: _____

Current Situation:

Is applicant currently in a **hospital/CBAT**?	☐ Yes	☐ No	Anticipated Discharge Date: _____
➢ If yes, where? _____			
Is applicant currently **homeless**?	☐ Yes	☐ No	
➢ If yes, involved agency, if any_____			
Is applicant currently **incarcerated**?	☐ Yes	☐ No	Anticipated Release Date: _____
➢ If yes, where? _____			
Is applicant currently on **probation/CRA**?	☐ Yes	☐ No	
➢ If yes, Probation Officer Name: _____			

If applicant is a parent or step parent, are there any children living with you? ☐ Yes ☐ No ☐ Not Applicable

Is the applicant currently involved with another state or federal *(i.e., VA)* agency? ☐ Yes ☐ No ☐ Unknown

If yes, which agency? *Check all that apply*

☐ DCF ☐ DDS ☐ EOEA ☐ DPH ☐ DYS ☐ MRC ☐ MCDHH ☐ MCB ☐ VA

Other Agency Contact _____ Phone # _____
Please Include a Release of Information *(Last)* *(First)*

Other Agency Contact _____ Phone # _____
Please Include a Release of Information *(Last)* *(First)*

Guardianship Information *(if applicable)*:

Does the applicant have a court appointed legal guardian? ☐ Yes ☐ No

- If yes, Guardianship Type: _____

Is there a DCF Guardian Mittimus in place? ☐ Yes ☐ No ☐ Unknown

- If yes, what type? _____

Important Information: *If the applicant has a court appointed guardian, please submit a copy of the Guardianship Decree with this application. The legal guardian (parent or court appointed) must sign the application and all the Authorizations for Releases of information for the application to be processed.*

Name of Legal Guardian _____ Relationship _____
(Last) (First) (Relationship to Applicant)

Guardian's address _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

How may we contact the guardian? *(Please check all that apply below, and provide phone number/e-mail address)*

☐	Day/Work Phone	( ) _____	May we leave a message? ☐ Yes ☐ No
☐	Evening Phone	( ) _____	May we leave a message? ☐ Yes ☐ No
☐	Cell Phone	( ) _____	May we leave a message? ☐ Yes ☐ No
☐	e-mail	_____	May we leave a message? ☐ Yes ☐ No

Sources of Income

☐ Employment ☐ SSI ☐ Social Security ☐ Family ☐ SSDI

☐ No Income Source ☐ Emergency Aid ☐ Other (Please Specify: _____

Education/School/College Information

Is applicant currently in school? ☐ Yes ☐ No ☐ Unknown

- If yes, school and town/city _____

Who is the responsible *Local Educational Agency* (LEA)? _____

Does applicant have an *Individualized Education Plan* (*IEP*)? ☐ Yes ☐ No ☐ Unknown

If Yes, what type of special education service(s) is the applicant receiving? (Please check all that apply.)

☐ Residential ☐ Day ☐ Unknown
☐ Other *(Please specify)*: _____

Is this a 688 referral? ☐ Yes ☐ No ☐ Unknown

Does applicant have a *504 Accommodation Plan*? ☐ Yes ☐ No ☐ Unknown

Health Insurance:

Current Coverage *(check all that apply)*:

☐ **Medicare:** Policy# _____

☐ **Medicaid/MassHealth:** Policy#: _____

Type: _____

Subscriber: _____

➢ Is applicant currently enrolled in ***Children's Behavioral Health Initiative*** (**CBHI**) Services? ☐ Yes ☐ No
If "yes," please identify services person is receiving and Community Service Agency (CSA) below.

- Name of *Community Service Agency* (CSA): _____
- CBHI service(s) applicant is currently receiving: _____

➢ Is applicant currently enrolled in an ***Accountable Care Organization*** (**ACO**)? ☐ Yes ☐ No
If "yes," please identify name and contact information below.

_____

➢ Is applicant currently enrolled in a ***Behavioral Health Community Partner*** (***BHCP***)? ☐ Yes ☐ No
If "yes," please identify name and contact information below.

_____

☐ **Commercial/Private** Policy#: _____

Insurance Company: _____

Subscriber: _____

☐ **No Health Insurance**

Is an application for health insurance pending? ☐ Yes ☐ No

If yes, please specify insurance: _____

Primary Mental Health Care Provider:

Please indicate who provides the applicant with regular mental health care. If there is no regular source of mental health care, use this section to indicate the most recent source of mental health care.

Primary Mental Health Provider: _____
(Last) *(First)*

Current Provider? ☐ Yes ☐ No

Agency Name: _____

Address: _____
(Number and Street) *(Apt No.)* *(City)* *(State)* *(Zip Code)*

Telephone Number: _____ Extension: _____

Diagnosis Information:

Does the applicant have a current psychiatric diagnosis? ☐ Yes ☐ No ☐ Unknown

If yes, please list all known diagnoses:

_____

_____

_____

_____

_____

_____

Other Supports

Name	**Relationship** *(e.g., family, therapist, clergy, etc.)*	**Address**	**Phone**	**Release of Information Included?** (Y/N)

General Physical Health:

Please indicate who provides regular medical care for the applicant. If there is no regular source of medical health care, use this section to indicate the most recent source of medical care.

Primary **Medical Care** Provider: _____ Current Provider? ☐ Yes ☐ No

Agency Name: _____

Provider's Address: _____

Provider's Phone Number: _____

Are there any medical problems that require ongoing care? ☐ Yes ☐ No ☐ Unknown

Has there ever been a diagnosis of a neurological problem? ☐ Yes ☐ No ☐ Unknown

If "yes," please describe any current medical or neurological problems:

_____

_____

_____

Medications

Is the applicant currently taking any medications? ☐ Yes ☐ No ☐ Unknown

If yes, please list **medications**, **dosages** and **prescriber**:

_____

_____

_____

_____

_____

_____

Why is the applicant applying for services?

_____

_____

_____

What kinds of services are needed?

_____

_____

_____

_____

DMH SERVICE AUTHORIZATION DETERMINATION

- I request that the Department of Mental Health (DMH) conduct a DMH service authorization determination. I have attached Signed *Authorization for Release of Information* forms to this application if necessary. I understand that DMH will collect and review medical records as part of the determination process. I understand that my name and information about me will be included in a DMH record keeping system.
- DMH may require a personal interview with me or a clinical evaluation in circumstances where the available clinical records are not sufficient to make a determination.
- I will be required to disclose information about my income and insurance and may be charged for services according to my ability to pay.
- I understand the decision of DMH may be appealed when it is determined the applicant is not approved for services because they do not meet the criteria for DMH services.
- I received a copy of the *DMH Notice of Privacy Practices* (appended to this request for services).
- I give permission to DMH to communicate about my request for DMH services with the person identified below who assisted with this application. This permission is valid until my application is fully processed or I notify DMH in writing that I revoke it.

Sign

_____ _____ _____

Signature of applicant or legal guardian of the person *Applicant Name (Please Print)* *Date Signed*

- Signed by: ☐ Parent ☐ Legal Guardian ☐ Applicant if an adult or emancipated minor
- Guardianship or DCF Mittimus documents attached? ☐ Yes ☐ No ☐ Unknown

PERSON ASSISTING APPLICANT

This section must be completed by the provider or other person assisting the applicant with the application.

Name _____ Relationship _____
(Last) (First) (Relationship to Applicant)

Agency Name: _____

Address: _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

Telephone# _____ ☐ Day ☐ Evening ☐ Cell

PROGRAM OR FACILITY SUBMITTING APPLICATION ON BEHALF OF APPLICANT

This section is to be completed by the program or facility submitting the application on behalf of applicant.

_____ _____
Name of Program or Facility *Name of Applicant*

☐ The applicant/guardian was informed on _____date that an application was being filed on their behalf and they did not object.
☐ The applicant lacks capacity and a petition for guardianship was filed in the appropriate court (copy of petition is attached)

Sign

_____ _____
Signature & title of person submitting application *Printed Name of person submitting application*

TO SUBMIT RELEASE OF MEDICAL INFORMATION FORMS

As part of the request for DMH Services determination process, DMH will review all available records of mental health care received by the applicant. **Please submit signed *Authorization for Release of Information* forms along with the application**.

1. Please submit one signed *Authorization for Release of Information* **form for each provider** of mental health care. If mental health care is provided through a clinic, please identify a primary provider of care at that clinic. Make additional copies of this form as needed.
2. In addition, please **submit** an *Authorization for Release of Information* **form for any other clinical information the applicant would like to have considered as part of the determination**. Make additional copies of this form as needed.
3. Please **check the accuracy** of the provider's name, address, and phone number on each release form. Correct names, addresses and phone numbers expedite the review process.
4. Please be sure to initial and sign all areas on the release of information (including the specially authorized release section)

How many *Authorizations for Release of Information* forms are being submitted with this application? ☐

DMH will also review any medical records that the applicant or those assisting the applicant may have in their possession and wish to submit for consideration.

5. Please complete and sign an Authorization for Release of Information form for each medical record that is attached to this application in case DMH staff needs to clarify information contained in the report.
6. Copies of medical records cannot be returned so please do not send original copies.

How many copies of medical reports are attached to this application? ☐

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: **Other Name(s):**

Address: **Phone:**

Social Security #: **Date of Birth:**

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: **Attention:** **Phone:**

Street: **City/Town:** **State**: **Zip:**

DMH Contact Information:

Name: **Phone:**

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify information to be released:

☐ Entire Record	☐ Discharge Summary	☐ Evaluations	☐ Treatment Plans
☐ Admission Documentation	☐ Transfer Summary	☐ Assessments & Tests	☐ Psychotherapy Notes
☐ ISPs & IAPs	☐ Physical Exam	☐ Lab Reports	☐ Consultations *(include name of consultant)*
☐ Psychiatry Notes	☐ Neuropsych Testing	☐ Other *(specify below)*	

_____
_____
_____
_____
_____

Purpose for the authorization (must check one):

☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

Or

☐ Coordinate care ☐ Facilitate billing

☐ Referral ☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify):_____

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information:_____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event)_____ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X _____ _____

Your signature or Personal Representative's signature Date

_____

Printed name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) _____

Specially Authorized Releases of Information (**please initial all that apply)**

____ To the extent that my medical record contains **information concerning alcohol or drug treatment** that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

____ To the extent that my medical record contains **information concerning HIV antibody and antigen testing** that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment; I specifically authorize disclosure of such information.

X _____ _____

Your signature or Personal Representative's signature Date

INSTRUCTIONS:

1. This form must be completed in full to be considered valid.

2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

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Social Security #: **Date of Birth:**

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Name: **Attention:** **Phone:**

Street: **City/Town:** **State**: **Zip:**

DMH Contact Information:

Name: **Phone:**

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify information to be released:

☐ Entire Record	☐ Discharge Summary	☐ Evaluations	☐ Treatment Plans
☐ Admission Documentation	☐ Transfer Summary	☐ Assessments & Tests	☐ Psychotherapy Notes
☐ ISPs & IAPs	☐ Physical Exam	☐ Lab Reports	☐ Consultations *(include name of consultant)*
☐ Psychiatry Notes	☐ Neuropsych Testing	☐ Other *(specify below)*	

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Or

☐ Coordinate care ☐ Facilitate billing

☐ Referral ☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify):_____

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COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information:_____

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X _____ _____

Your signature or Personal Representative's signature Date

_____

Printed name of signer

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DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
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Street: **City/Town:** **State**: **Zip:**

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COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information:_____

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X _____ _____

Your signature or Personal Representative's signature Date

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Printed name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

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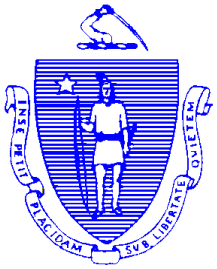

Commonwealth of Massachusetts
Department of Mental Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: December 15, 2010
Version 6

Privacy

The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.mass.gov/dmh), and will be available on request. Every privacy notice will be dated.

How Does DMH Use and Disclose PHI?

DMH may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to help make a determination on your application for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with DMH service providers for the purposes of referring you for DMH services and then for coordinating and providing the DMH services you receive.

To obtain payment - Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders

DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
    - **Clergy** – Your religious affiliation may be shared with clergy
    - **To Family and Friends** – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate

- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To EOHHS and/or its agencies, such as MassHealth, DCF, DDS, DYS, DTA and DPH for functions including service delivery, eligibility and program management.
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

*** These requests must be made in writing**

Record Retention

Your individual records relating to DMH provided care and services will be retained at a minimum for 20 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To Contact DMH or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114,
Phone: 617-626-8160, Fax: 617-626-8131, E-mail: PrivacyOfficer@dmh.state.ma.us. A complaint must be made in writing.

You also may contact a DMH facility's medical records office (for that facility's records), a DMH program director (for that program's records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the **Secretary of Health and Human Services**, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA. 02203.