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 12 & 13)

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: ***DMH Regulations 104 CMR 29.00***

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: ***Applying for DMH Services***

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

A *Request for DMH Services* application and **properly signed** *Authorization for Release of Information* forms must be delivered, mailed, faxed, or 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.

Office	Mailing Address	Phone Number	Fax Number	E-mail Address
Boston	85 East Newton Street Boston, MA 02118	(617) 626-9200	(617) 626-9216	MBA.serviceauthapplications@mass.gov
Brockton	165 Quincy Street, Brockton, MA 02302	(508) 897-2000	(508) 897-2047	SEA.serviceauthapplications@mass.gov
Northampton	1 Prince Street Northampton, MA 01060	(413) 587-6200	(413) 587-6240	WMA.serviceauthapplications@mass.gov
Tewksbury	P.O. Box 387 Tewksbury, MA 01876-0387	(978) 863-5000	(978) 863-5091	Under 18: NEA.CYFServiceAuthRequest@mass.gov 18 & Older: NEA.serviceauthapplications@mass.gov
Worcester	361 Plantation Street Worcester, MA 01605	(774) 420-3140	(774) 420-3165	CMA.serviceauthapplications@mass.gov

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.

For information about how to send an application and supporting documents to DMH by secure e-mail: ***Secure E-mail***

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 Ethnicity section 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 in the application 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.

Ethnicity Examples				
Albanian	Colombian	Haitian	Laotian	Puerto Rican
American - USA	Congolese	Hmong	Lebanese	Russian
Armenian	Costa Rican	Honduran	Mexican	Salvadoran
Bhutanese	Dominican	Indian	Moroccan	Somali
Bosnian	Egyptian	Iranian	Nigerian	Thai
Brazilian	Eritrean	Iraqi	Nicaraguan	Tibetan
Burmese	Ethiopian	Irish	Pakistani	Ukrainian
Cambodian	Filipino	Israeli	Peruvian	Venezuelan
Canadian	French	Italian	Panamanian	Vietnamese
Cape Verdean	Greek	Japanese	Polish	West Indian/Caribbean
Chinese	Guatemalan	Korean	Portuguese	

City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office	City or Town	DMH Office
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 Office
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

I. Applicant Information

1	**Applicant Legal Name**	*Last Name* / *First Name* / *M.I*
2	**Applicant Preferred Name** *(If different than legal name)*	*Last Name* / *First Name*
3	**Primary Address** *(or last known address if person is homeless)* Street Street 2 (Apt#) City, State & Zip Code	
4	**Mailing Address** *(if different than address above)* Street Street 2 (Apt#) City, State & Zip Code	
5	**How can we reach you?** *(Please provide phone number/e-mail address for all that apply)* Day/Work Time Phone — May we leave a message? <Select> Evening Phone — May we leave a message? <Select> Cell Phone — May we leave a message? <Select> E-mail Address — May we send e-mail? <Select>	
6	**Date of Birth**	**Age**: **Social Security Number**:
7	**Gender Identity** <Select> Specify if "Other":	
8	**Marital Status** <Select>	
9	**Race** ☐ Asian ☐ American Indian/Alaskan Native ☐ Black or African American ☐ Unknown ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Chooses not to self-identify ☐ Other Specify if "Other":	
10	**Hispanic/Latino/Latinx?** <Select>	
11	**Ethnicity**	
12	**Preferred Language** Parent/Guardian preferred language *(If applicant is under 18)* Is an interpreter needed? <Select> If yes, for whom?	
13	Is applicant **deaf** or **hard of hearing**? <Select>	
14	Is applicant **legally blind** (vision < 20/200 or totally blind)? <Select>	
15	If 18 or older, is applicant a **registered voter** *(optional)*? <Select>	
16	Has applicant served in the **military**? <Select>	
17	Was applicant adopted or in the **adoption** process? <Select>	
18	**Custody** If applicant is under age 18, who has **legal** custody? <Select> If applicant is under age 18, who has **physical** custody? <Select>	

II. Additional Contact Information

19	**Name of Emergency Contact** Relationship to Applicant Address Phone Number(s) E-Mail Address
20	**Parent/Agency Contact #1** Relationship to Applicant Address Phone Number(s) E-Mail Address
21	**Parent/Agency Contact #2** Relationship to Applicant Address Phone Number(s) E-Mail Address

III. Current Situation

22	**Is applicant currently in a hospital/CBAT?** <Select> If "yes," anticipated Discharge Date If "yes," facility name?
23	**Is applicant currently homeless?** <Select> If "yes," involved agency, if any
24	**Is applicant currently incarcerated?** <Select> If "yes," anticipated Release Date If "yes," facility name?
25	**Is applicant currently on probation/CRA?** <Select> If "yes," Probation Officer name
26	If applicant is a **parent or step parent**, are there any children living with them? <Select>
27	Is applicant currently involved with **another state or federal** ***(i.e., VA)*** **agency**? <Select> If "yes," which agency *(check all that apply)*? ☐ DCF ☐ DDS ☐ DPH ☐ DYS ☐ EOEA ☐ MCB ☐ MCDHH ☐ MRC ☐ VA Other Agency Contact Name ***Please include a Release of Information*** Contact's Phone Number Other Agency Contact Name ***Please include a Release of Information*** Contact's Phone Number

IV. Guardianship Information

28	Does the applicant have a court appointed legal guardian? <Select> If "yes," Guardianship Type
29	Is there a DCF Guardian Mittimus in place? <Select> 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.***

IV. Guardianship Information *(Continued)*

30
Name of **Legal Guardian**
Relationship to Applicant
Address
Day/Work Time Phone — May we leave a message? <Select>
Evening Phone — May we leave a message? <Select>
Cell Phone — May we leave a message? <Select>
E-mail Address — May we send e-mail? <Select>

V. Sources of Income

31 Applicant's current **sources of income**

☐ Employment ☐ SSI ☐ SSDI ☐ Social Security
☐ No Income Source ☐ Emergency Aid ☐ Family
☐ Other *(please specify)*:

VI. Education/School/College Information

32 Is applicant **currently in school**? <Select>
If "yes,'" school and town/city

33 Responsible *Local Educational Authority* (LEA)?

34 Does applicant have an *Individualized Education Plan* (IEP)? <Select>
If "yes," what type of educational service(s) is the applicant receiving? *(Check all that apply)*
☐ Residential ☐ Day Services ☐ Unknown ☐ Other:

35 Is this a ***688** Referral*? <Select>

36 Does applicant have a ***504** Accommodation Plan*? <Select>

VII. Health Insurance Information - Current Coverage *(check all that apply)*

37

☐ **Medicare** Policy#:

☐ **Medicaid/MassHealth** Policy#:
Type:
Subscriber:

1. Is applicant enrolled in ***Children's Behavioral health Initiative (CBHI)*** Services? <Select>
If "yes," name of Community Service Agency (CSA)?If
"yes," CBHI Services applicant is currently receiving:

2. Is applicant currently enrolled in an ***Accountable Care Organization (ACO)?*** <Select>
If "yes," name and contact information:

3. Is applicant currently enrolled in ***Behavioral Health Community Partner (BHCP)*?** <Select>
If "yes," name and contact information:

☐ **One Care** Plan:

☐ **Commercial/Private** Policy#:
Insurance Company:
Subscriber:

☐ **No Health Insurance**
Is an application for health insurance pending? <Select>
If "yes," specify insurance:

VIII. 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.*

38

Primary **Mental Health** Provider

Is this a current provider? <Select>

Agency Name

Street Address

City, State and Zip Code

Phone Number(s)

IX. Diagnosis Information

39

Does the applicant have a current psychiatric diagnosis? <Select>

Please list all known diagnoses and codes:

X. Other Supports

Name	Relationship	Address	Phone#	Is Release of Information Included?
				<Select>
				<Select>
				<Select>
				<Select>
				<Select>
				<Select>

XI. 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.*

40 Primary **Medical Care** Provider

Is this a current provider? <Select>

Agency Name

Street Address

City, State and Zip Code

Phone Number(s)

41 Are there any medical problems that require **ongoing care**? <Select>

42 Has there ever been a diagnosis of a **neurological** problem? <Select>

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

XII. Medications

43 Is the applicant taking any **medications**? <Select>

If "Yes," please list **medications, dosages** and **prescriber:**

XIII. Service Needs

44 Why is the applicant applying for DMH services?

45 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.

Electronic Filing Statement:

You may sign this document by providing your electronic signature below and sending to DMH via secure e-mail.

If you prefer to submit your application on paper, please print and complete this form using a hand-written signature below. If you are unable to print the application, you may contact a DMH office to request a copy be mailed to you at no charge (see page 2 above for DMH Area Office contact information).

You may withdraw your consent to use an electronic signature at any time by contacting the DMH office where you submitted your application for services. If you withdraw your electronic signature consent, DMH will be unable to continue to process your application for services, unless you chose to submit a paper application.

You may update your contact information by contacting the DMH office where you submitted your application for services.

Please save or print a copy of this document for your records. Upon receipt of your application, DMH will contact you to verify the information provided. Once verified, a copy of your application will be sent to you via secure email or regular mail at your preference.

If signed electronically, you consent to the use of your electronic signature on this document. This consent only applies to the DMH application process.

In order to complete this process we will likely need hand signed authorization(s) to release information to share and receive information from the applicant's healthcare/education providers. We will be in touch with you to obtain the necessary authorization.

Signature of applicant or legal guardian of the person

Sign _____ _____ _____

Signature *Applicant Name (Please Print/Type)* *Date Signed*

Signed By: <Select>

Are Guardianship or DCF Mittimus documents attached? <Select>

PERSON ASSISTING APPLICANT

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

Name _____

Relationship to Person _____

Agency Name _____

Address _____

(Number and Street) (City) (State) (Zip Code)

Phone# _____ ☐ 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*

☐ Date applicant/guardian was informed 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* | *Printed Name of person submitting application* | *Date Signed*

Please note: If this application is submitted via e-mail, and a hand signature is not possible, please type your name in both the *Signature* field above. DMH will process this application based upon receipt of your typed signature. In order to complete this process we will likely need hand signed authorization(s) to release information to share and receive information from the applicant's healthcare/education providers. We will be in touch with you to obtain the necessary authorization.

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.

1. 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.
2. 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?

Important Instructions about Completing the Authorizations for Releases of Information

Please review the information below before completing the Authorizations for Releases of Information on the following pages.

Authorizations for Releases of Information that are not properly completed can delay the application process. *Authorizations for Releases of Information* need to be completed and signed correctly to meet the requirements of healthcare/education providers; electronic signatures are **not** acceptable and must always include a **hand signature**. DMH can mail the forms to you on request.

Please see information below for guidance on how to complete each section of the *Authorizations for Release of Information*.

Section 1: Patient Application Information

Applicant demographic information is used to locate records. Some information is pre-populated based on what was documented earlier on the application form. Please review for accuracy, make corrections if needed and add information if missing.

Section 2: Person/Agency to Release Information

Complete as much of the left side of this section as possible. The *DMH Service Authorization Unit* mailing address section on the right will be inserted by DMH.

Section 3: Information you want shared

Check off all documents the Person/Agency might have in their records that will help DMH in its review of the application, or check the "Entire Mental Health record" option.

Section 4: Date Range

Enter a date range for the records the applicant/Legally Authorized Representative (LAR) agrees can be sent to DMH. Alternatively, if you are unsure of the time period, the "Past 3 years" box can be checked.

Section 5 (upper): HIV and Substance Abuse Information

Enter your **initials** if the applicant/LAR agrees that information about HIV Testing and Substance Use can be released to DMH. If not initialed, the Person/Agency will need to redact this information from the records they send to DMH. It is important that **initials** are entered in the boxes provided, and not an "x" or other type of mark.

Section 5 (lower): Expiration Date

Enter the date you would like DMH's permission to share records and communicate with the Person/Agency to end. If no date is entered, the *Authorization for Release of Information* will automatically expire in one year from the date it is signed, or when DMH is no longer providing services, whichever comes first.

Section 6: Signature

It's very important that the *Authorizations for Release of Information* include a hand signature and date to the right of the "x". The Person/Agency with the records will not honor an *Authorization for Release of Information* that does not have a hand signature to confirm permission was granted by the applicant or LAR. A typed name is helpful for signatures that are illegible, but will not qualify as a signature.

The signature of a LAR (i.e., guardian or custodial parent) is needed if applicable. In these situations, the guardian must provide a hand signature and date to the left of the "x," type their name in the space provided, indicate the type of authority they have and provide a copy of court order (if applicable) to verify they are legally authorized to sign for the applicant.

Authorization for Release of Information
Two Way

1. Patient/Applicant Information			
Name:		Other Names:	
Street:		Apt.#:	
City/Town:		State:	Zip Code:
Last 4 digits of SSN:		Date of Birth:	
Phone:			

2. Authorization to Release: I authorize the Department of Mental Health (DMH) to receive and release information, including confidential communications, from or to the Person, Agency or Facility named below, either verbally or in writing.

Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)		DMH Service Authorization Unit ***For DMH Use Only***
Name:		
Attention:		
Street:		
City/Town		
State/Zip Code:		
Phone:		
Fax:		

3. Check to indicate the information you want shared: (*check* all that apply)

☐ Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.		
☐ Entire Mental Health Record, *excluding Psychotherapy Notes which require a separate authorization*		
☐ Discharge Summary		☐ Treatment Plans
☐ ISPs & IAPs	☐ Neuropsych Testing	☐ Transfer Summary
☐ Admission Documentation	☐ Physical Exam	☐ Lab Reports
☐ Other (please specify) / additional information:		

4. Dates of the information you want shared: (Specify dates OR select 3 year period by checking the box)

Dates of Requested Information: From: To:

OR ☐ For the 3 year period prior to the date of this authorization.

Authorization for Release of Information
Two Way

Patient/Applicant Name:

5. Please *initial* to indicate that you give permission to release the following information if present in your record: (*initial* all that apply)	
☐	HIV test results (Authorization required for each release request.)
☐	Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Purpose of the Release: Service authorization.

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 the DMH address identified on page one or the DMH office in my area. (Find DMH area offices at www.mass.gov/dmh-offices-facilities-and-staff-directory; call 1-800-221-0053; or email dmhinfo@MassMail.State.MA.US.)
- The revocation will not apply to information that has already been released pursuant to this authorization.
- 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.
- Once the above information is released, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations.
- Authorizing the 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.

This authorization will expire (specify a date, time period or an event) _____ or, if nothing is specified, it will expire the later of (i) one year from date of signing; or (ii) if applicable, when I am no longer receiving services from DMH.

6. Signature / Authorization: **Sign and provide information as required below**.

X _____ _____

Your **hand-signature**, or that of a Personal Representative's is **Required** Date

_____

Print name of signer

The following information is needed if signed by a personal representative:

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

If court appointed provide copy of court order.

Authorization for Release of Information
Two Way

1. Patient/Applicant Information			
Name:		Other Names:	
Street:		Apt.#:	
City/Town:		State:	Zip Code:
Last 4 digits of SSN:		Date of Birth:	
Phone:			

2. Authorization to Release: I authorize the Department of Mental Health (DMH) to receive and release information, including confidential communications, from or to the Person, Agency or Facility named below, either verbally or in writing.

Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)		DMH Service Authorization Unit ***For DMH Use Only***
Name:		
Attention:		
Street:		
City/Town		
State/Zip Code:		
Phone:		
Fax:		

3. Check to indicate the information you want shared: (*check* all that apply)

☐ Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.		
☐ Entire Mental Health Record, *excluding Psychotherapy Notes which require a separate authorization*		
☐ Discharge Summary		☐ Treatment Plans
☐ ISPs & IAPs	☐ Neuropsych Testing	☐ Transfer Summary
☐ Admission Documentation	☐ Physical Exam	☐ Lab Reports
☐ Other (please specify) / additional information:		

4. Dates of the information you want shared: (Specify dates OR select 3 year period by checking the box)
Dates of Requested Information: From: To:
OR ☐ For the 3 year period prior to the date of this authorization.

Authorization for Release of Information
Two Way

Patient/Applicant Name:

5. Please *initial* to indicate you give permission to release the following information if present in your record: (*initial* all that apply)	
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Purpose of the Release: Service authorization.

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 the DMH address identified on page one or the DMH office in my area. (Find DMH area offices at www.mass.gov/dmh-offices-facilities-and-staff-directory; call 1-800-221-0053; or email dmhinfo@MassMail.State.MA.US.)
- The revocation will not apply to information that has already been released pursuant to this authorization.
- 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.
- Once the above information is released, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws or regulations.
- Authorizing the disclosure of the information identified above is voluntary.
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6. Signature / Authorization: **Sign and provide information as required below**.

X _____ _____

Your signature or Personal Representative's signature **(Required)** Date

_____

Print name of signer

The following information is needed if signed by a personal representative:

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

If court appointed provide copy of court order.

Authorization for Release of Information
Two Way

1. Patient/Applicant Information			
Name:		Other Names:	
Street:		Apt.#:	
City/Town:		State:	Zip Code:
Last 4 digits of SSN:		Date of Birth:	
Phone:			

2. Authorization to Release: I authorize the Department of Mental Health (DMH) to receive and release information, including confidential communications, from or to the Person, Agency or Facility named below, either verbally or in writing.

Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)		DMH Service Authorization Unit ***For DMH Use Only***
Name:		
Attention:		
Street:		
City/Town		
State/Zip Code:		
Phone:		
Fax:		

3. Check to indicate the information you want shared: (*check* all that apply)

☐ Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.		
☐ Entire Mental Health Record, *excluding Psychotherapy Notes which require a separate authorization*		
☐ Discharge Summary		☐ Treatment Plans
☐ ISPs & IAPs	☐ Neuropsych Testing	☐ Transfer Summary
☐ Admission Documentation	☐ Physical Exam	☐ Lab Reports
☐ Other (please specify) / additional information:		

4. Dates of the information you want shared: (Specify dates OR select 3 year period by checking the box)
Dates of Requested Information: From: _____ To: _____.
OR ☐ For the 3 year period prior to the date of this authorization.

Authorization for Release of Information
Two Way

Patient/Applicant Name:

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- The revocation will not apply to information that has already been released pursuant to this authorization.
- 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.
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6. Signature / Authorization: **Sign and provide information as required below**.

X _____ _____

Your signature or Personal Representative's signature **(Required)** Date

_____

Print name of signer

The following information is needed if signed by a personal representative:

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

If court appointed provide copy of court order.

Authorization for Release of Information
Two Way

1. Patient/Applicant Information			
Name:		Other Names:	
Street:		Apt.#:	
City/Town:		State:	Zip Code:
Last 4 digits of SSN:		Date of Birth:	
Phone:			

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Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)		DMH Service Authorization Unit
Name:		***For DMH Use Only***
Attention:		
Street:		
City/Town		
State/Zip Code:		
Phone:		
Fax:		

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☐ Other (please specify) / additional information:		

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Your signature or Personal Representative's signature **(Required)**

Print name of signer

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Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)		DMH Service Authorization Unit
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Authorization for Release of Information
Two Way

Patient/Applicant Name:

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- 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.
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- Authorizing the disclosure of the information identified above is voluntary.
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6. Signature / Authorization: **Sign and provide information as required below**.

X _____ _____

Your signature or Personal Representative's signature **(Required)** Date

_____

Print name of signer

The following information is needed if signed by a personal representative:

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

If court appointed provide copy of court order.

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.
PLEASE REVIEW IT CAREFULLY

Notice Effective Date: March 1, 2022

Privacy

The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy and security 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. Information about care that you received from other providers may also be included in your PHI.

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.

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, on the DMH website (www.state.ma.us/dmh), and will be available on request. Every privacy notice will be dated.

How DMH MAY Use and Disclosure Your PHI

DMH may use your PHI within the DMH organization and disclose it outside of the organization without your authorization for the following purposes:

1. For Treatment - DMH may use/disclose PHI to doctors, nurses, residents or students and other health care providers that are involved in delivering your health care and related services. Your PHI will be used to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be disclosed to other health care professionals and providers to obtain prescriptions, lab work, consultations, and other items needed for your care. PHI will be disclosed to health care providers for the purposes of referring you for services and then for coordinating and providing the services you receive.

2. For Payment - 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.

3. 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).

4. Appointment Reminders - DMH may use PHI to remind you of an appointment or follow up instructions or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

5. Business Associates - DMH may use/disclose PHI to contractors, agents and other business associates who need the information to assist DMH with obtaining payment or carrying out its business operations. If DMH discloses your PHI to a business associate, DMH will have a written contract with that business associate to ensure that it also protects your PHI.

6. Family and Friends/Clergy - DMH may disclose a limited amount of PHI for the following purposes:

- **Clergy** – If you agree, verbally or otherwise, your religious affiliation may be disclosed to clergy.
- **To Family, Friends or Others** – If you agree or do not object, PHI may be disclosed to persons involved in your care or payment for your care if directly related to their involvement in your care or payment for your care.

7. **Required by Law -** DMH may use/disclose PHI as required by law, such as to report a felony committed on its premises; pursuant to a court order; to report abuse or neglect, and other situations where DMH is required to make reports and/or disclose PHI pursuant to a statute or regulation.

8. **Lawsuits and Disputes** - If you bring a legal action or other proceeding against DMH or our employees or agents, we may use and disclose PHI to defend ourselves.

9. **Other Purposes -** DMH may use/disclose your PHI:
    - For guardianship or commitment proceedings when DMH is a party;
    - For other judicial and administrative proceedings if certain criteria are met;
    - To public health authorities that are to receive reports of abuse or neglect;
    - For research purposes, following strict internal review;
    - To law enforcement officials when the person alleged to have committed a crime against you is a DMH facility or program staff member.
    - To avert a serious and imminent threat to health or safety;
    - To persons involved in your care in an emergency situation if certain criteria are met;
    - To correctional institutions if you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined;
    - To authorized public health officials for public health activities such as tracking diseases and reporting vital statistics;
    - To government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operations of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws;
    - For workers' compensation claims;
    - For certain specialized government functions if certain criteria are met; and

- In the unfortunate event of your death, we may disclose your PHI to coroners, medical examiners, funeral directors, and certain organ and tissue procurement organizations.

Uses/Disclosures Requiring Written Authorization

DMH is required to have a written authorization from you or your legally authorized personal representative for uses/disclosures beyond treatment, payment, and health care operations, unless an exception listed above 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.

Authorization is required for most uses and disclosures of psychotherapy notes (these are the notes that certain professional behavioral health providers maintain that record your appointments with them and are not stored in your medical record), certain substance use disorder information, HIV testing or test results, and certain genetic information even if disclosure is being made for treatment, payment, or health care operations purposes as described above.

Although the following types of uses/disclosures are not contemplated by DMH, we need to inform you that any use or disclosure of PHI for marketing that involves financial remuneration to DMH will require an authorization. Similarly, to sell PHI, DMH must obtain an authorization. DMH will not use or disclose your PHI for fundraising purposes.

Your Rights Concerning Your PHI

You or your legally authorized personal representative has the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH will try to accommodate all reasonable requests.
- 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 request a copy of the PHI used to make decisions about your care. When records are kept electronically, you may request an electronic copy. Access to your records may be restricted in limited circumstances. If DMH denies your request, in whole or in part, you may request that the denial be reviewed. Fees may be charged for copying and mailing. Ordinarily, DMH will respond to your request within 30 days. If additional time is needed to respond, DMH will notify you within the 30 days to explain the reason(s) for the delay and indicate when you can expect a final answer to your request. **This request must be made in writing.**
- Request additions or corrections to your PHI. DMH is not required to agree to such a request. If it does not comply with your request, DMH will tell you why in writing within 60 days and notify you of your specific rights in that event. If additional time is needed to respond, DMH will notify you within the 60 days to explain the reason(s) for the delay and indicate when you can expect a final answer to your request. **This request must be made in writing.**
- Request an accounting of disclosures (up to the past six years) which will identify, in accordance with applicable laws, certain other persons or organizations to which DMH disclosed your PHI and why. An accounting will not include disclosures that were: (1) made to you or your personal representative; (2) authorized or approved by you; (3) made for treatment, payment, and health care operations; and (4) some that were required by law to be made. Ordinarily, DMH will respond to your request within 60 days. If additional time is needed to respond, DMH will notify you within the 60 days to explain the reason(s) for the delay and indicate when you can expect a final answer to your request. **This request must be made in writing.**

- Request that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to such restriction, with the exception that if you, or someone on your behalf, pay for a service or health care item out-of-pocket in full, DMH will agree to not disclose PHI pertaining only to that service or item with your health plan for the purpose of payment or health care operation, unless DMH is otherwise required by law to disclose that PHI. **This request must be made in writing.**

The above requests may be made at or submitted to any DMH facility or office.

Record Retention
Your individual records will be retained a minimum of 20 years from the last date you receive services from a DMH inpatient facility and/or from DMH operated community services. After that time, your records may be destroyed.

Breach of PHI
DMH will inform you if a breach of your unsecured PHI occurs.

Complaint
If you believe that your privacy or 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, E-mail: DMHPrivacyOfficer@MassMail.State.MA.US, Phone: 617-626-8160, Fax: 617-626-8242. A complaint must be made in writing.

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.

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

Privacy Contact Information
If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, E-mail: DMHPrivacyOfficer@MassMail.State.MA.US, Phone: 617-626-8160, Fax: 617-626-8131. 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.

DMH Contact Information
If you want to obtain other information (non-privacy related) about DMH and its services you may contact: DMH Information, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, E-mail: dmhinfo@state.ma.us, Phone: 800-221-0053, Fax: (617) 626-8131.

You also may contact your DMH program director, your site office, or the human rights officer at your facility or program, for more information or assistance.