Child & Adolescent Mental Health Division

FAMILY APPLICATION FOR SERVICES INSTRUCTIONS

Complete as much of this form as possible. If you are unsure what to include, please see instructions below. If you are still unable to complete a part of the form, leave it blank and we will work with you to complete it.

Youth Information

Primary MedQUEST Insurance Plan:

- You can find this information on your insurance card. If you are not sure, leave the information blank and we will assist you.

Secondary Insurance:

- You may have more than one insurance provider. If you do, please list what information you have for this item.
- If you do not have more than one insurance, leave this item blank.

Background Question(s)

Has your child been evaluated for emotional or behavior reasons before?

- This may include evaluations by the school or by a therapist or counselor outside of the school

Primary Legal Guardian Information

I have the legal right to sign consent for this youth:

- If you are not the biological or adoptive parent, please provide documentation that you have guardianship or power of attorney for the youth.

Additional Legal Guardian Information

(Complete this section only if there is more than one guardian or caregiver)

I have the legal right to sign consent for this youth:

- If this "additional legal guardian" is not the biological or adoptive parent, please provide documentation if s/he has guardianship or power of attorney for the youth.

Consent – Parent or Legal Guardian's Signature

- Only sign if you are the legal guardian or have power of attorney.
- Signing this shows us that we have the right to evaluate the child for to determine if s/he is eligible for services.
- Signing also shows you that we will not release information about the youth without the permission of you, the signer.

Agency Contact Information

- Parents do not need to complete this section.
  - This section will only be completed by the agency that referred the family to services. If there is no referring agency, leave this part of the form blank.

Child & Adolescent Mental Health Division

Authorization to Jointly Disclose Protected Health Information (PHI)

Purpose:
This part of the application allows CAMHD/the Family Guidance Center, to share needed information with other agencies that may be involved in providing care to the youth.

Instructions:

- Lists the youth's first and last name, address, and date of birth.
- Initial ONLY next to agencies to whom you would like to provide or allow to receive your health information, such as psychological evaluation, to help coordinate care.
- If you want to authorize the sharing of the youth's substance abuse treatment information, please initial where indicated.
- Please read the sections on the rest of the page which describe the purpose and expiration of the authorization, as well as your rights.
- If you agree to the above, please sign and date the form. Print your name and write your relationship to the child (Description of Personal Representative's Authority).
- Page 2 of the Child and Adolescent Mental Health Division (CAMHD), Authorization to Jointly Disclose Protected Health Information (PHI).
    - Check off the agencies and addresses that match the ones you initialed on the first page.
    - Please write the name of the youth on the bottom of the page. Provide the Customer ID Number if you know it.

After you have completed as much of the form as possible, please identify which Family Guidance Center is the nearest to you (addresses are listed on the first page of the packet) and mail it in.

State of Hawaii
Department of Health
Child & Adolescent Mental Health Division
3627 Kilauea Avenue, Room 101
Honolulu, Hawaii 96816
(808) 733-9333

For the Department of Education

For Educationally Supported (IDEA) referrals, please complete as much of the CAMHD Department of Education Referral form as possible. Assist the family in completing the intake form, making sure that parent or legal guardian has signed both the intake form and the attached inter-agency consent form. Once all forms have been completed, please send them in to the appropriate Family Guidance Center.

For MedQUEST referrals, please complete the Agency Contact Information section of the Family Application for CAMHD Services. Assist the family in completing the intake form, making sure that parent or legal guardian has signed both the intake form and the attached inter-agency consent form. Once all forms have been completed, please send them in to the appropriate Family Guidance Center.

CAMHD Family Guidance Centers

Hawaii

East Hawaii FGC - Hilo
88 Kanoelehua Ave, Suite B-107
Hilo, Hawaii 96720
Phone: (808) 933-0610
Fax: (808) 933-0558

West Hawaii FGC - Waimea
Carter Professional Building
65-1230 Mamalahoa Highway,
Suite A-1
Kamuela, Hawaii 96743
Phone: (808) 887-8100
Fax: (808) 887-8113

Kauai

Kauai FGC
3059 Umi Street, Room A014
Mailing: 3059 Umi Street, BSMT14
Lihue, HI 96766
Phone: (808) 274-3883
Fax: (808) 274-3889

Maui (Including Hana, Lahaina and Lanai)

Maui FGC - Wailuku
270 Waiehu Beach Road, Suite 213
Wailuku, Hawaii 96793
Phone: (808) 243-1252
Fax: (808) 243-1254

Molokai

Maui FGC - Molokai
65 Makaena Place, #107
Mailing: P.O. Box 2007
Kaunakakai, Hawaii 96748
Phone: (808) 553-7878
Fax: (808) 553-7874

Oahu

Central Oahu FGC - Pearl City
860 Fourth Street, 2nd Floor
Pearl City, Hawaii 96782
Phone: (808) 453-5900
Fax: (808) 453-5940

Central Oahu FGC - Kaneohe
45-691 Keaahala Road
Kaneohe, Hawaii 96744
Phone: (808) 233-3770
Fax: (808) 233-5659

Honolulu FGC
3627 Kilauea Avenue, Room 401
Honolulu, Hawaii 96816
Phone: (808) 733-9393
Fax: (808) 733-9377

Leeward Oahu FGC
601 Kamokila Boulevard,
Room 355
Kapolei, Hawaii 96707
Phone: (808) 692-7700
Fax: (808) 692-7712

Child & Adolescent Mental Health Division

Family Application for CAMHD Services

Youth Information

Name: _____ **Date of Birth:** _____

Preferred Name: _____ **Gender:** ○ Male ○ Female

School: _____ **Grade:** _____ **Gender Identity:** _____

Primary MedQUEST Insurance Plan: ○ AlohaCare ○ OHANA ○ HMSA ○ UHA ○ Kaiser

○ None ○ Other: _____ **Insurance ID:** _____

Secondary MedQUEST Insurance Plan: ○ AlohaCare ○ OHANA ○ HMSA ○ UHA ○ Kaiser

○ None ○ Other: _____ **Insurance ID:** _____

SSN: _____ **Primary Care Provider:** _____

Who does your child live with? ○ Parents ○ Relatives ○ Foster Family ○ Other: _____

How did you hear about our services? ☐ DOH Website ☐ School ☐ Primary Care Provider ☐ Brochure

☐ Child Welfare Service ☐ Therapist ☐ Probation Officer

☐ Other: _____

Youth's Preferred Language: _____

Background Questions

Has your child been evaluated for emotional or behavioral reasons before?

○ Yes ○ No ○ I don't know

Why is your family seeking mental health services?

_____

_____

_____

Primary Legal Guardian Information

Name: _____

Guardian's Preferred Language: _____

Primary Phone Number: _____ **Secondary Phone Number:** _____

Relationship to Youth: O Mother O Father O Grandparent O Aunt or Uncle O Foster Parent O CWS Social Worker

O OYS Administrator O Other: _____

I have the legal right to sign consents for this youth: O Yes O No

Email: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Additional Guardian Information *Please complete if there is an additional caregiver*

Name: _____

Guardian's Preferred Language: _____

Primary Phone Number: _____ **Secondary Phone Number:** _____

Relationship to Youth: O Mother O Father O Grandparent O Aunt or Uncle O Foster Parent O CWS Social Worker

O OYS Administrator O Other: _____

I have the legal right to sign consents for this youth: O Yes O No

Email: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

I attest that the information given is complete and correct, and that I have the legal right to sign consents for this youth.

I hereby consent to the evaluation of my child for the purpose of determining eligibility, and agree to CAMHD program enrollment, and agree that CAMHD may obtain information about my child with the understanding that it cannot be disclosed to others without my further approval, except the agency that has referred you and completed this packet, unless permitted by Federal or State law. I also understand that this consent expires in one year.

Parent or Legal Guardian Signature: _____ **Date:** _____

Agency Contact Information

To be completed by referring agency only. If there is none, leave blank.
If a state agency is making this referral the agency must complete this section, and the "Authorization for Use or Disclosure of Protected Health Information (PHI)" at the end of this packet as appropriate.

Agency: ○ CWS ○ OYS ○ DHS ○ PO ○ DOE ○ Other: _____

Referral Program Type: ○ MedQUEST/SEBD ○ DOE/IDEA ○ OYS/MOA ○ PK Only

Form completed by: ☐ Agency Contact ☐ Guardian ☐ Youth Case Worker

☐ Other: _____

Name: _____ **Phone Number:** _____

Email: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Relationship to Youth: ○ Foster Parent ○ CWS Social Worker ○ DOE/SBBH

○ Parole Officer ○ Probation Officer ○ OYS Administrator

○ Other: _____

Title: _____

HYCF Intake Date: _____ **HYCF Projected End Date:** _____

Parole Start Date: _____ **Parole Projected End Date:** _____

Probation Start Date: _____ **Probation Projected End Date:** _____

CWS Status: _____

CWS Start Date: _____ **Projected CWS End Date:** _____

I have the legal right to sign consents for this youth: ○ Yes ○ No

Reason for Referral:

_____

_____

_____

List of social, emotional, and behavioral health needs:

_____

_____

_____

Child & Adolescent Mental Health Division

Authorization to Jointly Disclose Protected Health Information (PHI)

Individual Whose Protected Health Information is Being Disclosed

First Name:	Last Name:
Address:	Birth Date:
FROM: Child and Adolescent Mental Health Division 3627 Kilauea Avenue, Room 101, Honolulu HI 96816	**TO: All Parties Identified Below**
FROM: All Parties Identified Below	**TO: Child and Adolescent Mental Health Division** 3627 Kilauea Avenue, Room 101, Honolulu HI 96816

*Please **INITIAL** all agencies your information may be disclosed with.*

Department of Health
___ Developmental Disabilities Division
___ Early Intervention Section
___ Alcohol and Drug Abuse Division

Juvenile Client Services Branch
___ Oahu – First Circuit
___ Maui – Second Circuit
___ Hawaii – Third Circuit
___ Kauai – Fifth Circuit

University of Hawaii
___ Psychology (First Episode Psychosis /Eval/CCBT)
___ Psychiatry (Telepsych/Eval)

Department of Education
___ Honolulu District
___ Central District
___ Leeward District
___ Windward District
___ Hawaii District
___ Kauai District
___ Maui District

Department of Human Services
___ Child Welfare Services Branch
___ Office of Youth Services
___ Med-QUEST Division

___ **Other**:
___ **Other**:

Providers
___ Alaka`i Na Keiki
___ Aloha House
___ Benchmark Behavioral Health Services
___ Bobby Benson Center (BBC)
___ CARE Hawaii, Inc.
___ Catholic Charities Hawaii (CCH)
___ Child & Family Service
___ Hale Kipa Inc.
___ Hale `Opio Kauai, Inc.
___ Hawaii Behavioral Health (HBH)
___ Hina Mauka
___ Maui Youth & Family Services
___ Parents and Children Together (PACT)
___ Queen's Medical Center (QMC)
___ Salvation Army
___ Sutter Health Pacific dba Kahi Mohala Behavioral Hospital
___ Waianae Coast Comp. Health Center - Hale Na'au Pono

I authorize that the following Protected Health Information be used or disclosed: **Any and all information relevant to mental health care coordination, treatment planning, access to resources, assessments and supports. This includes but is not limited to:**

- **Clinical Management Plan; Coordinated Service Plans; Mental Health related assessments and evaluations**
- **Provider mental health treatment plans and progress reports**
- **Court hearings, reports and orders**
- **Individualized Educational Plans and Department of Education (DOE) health-related documents**
- **Functional Behavioral Assessments and Behavioral Support Plans**
- **Mental Health-related medical records**
- **Department of Human Services (DHS)**
- **Type of Records:**
- **Other:**

Initial here if your authorization includes the disclosure of Substance Abuse Treatment information: _____ (initials)

The Protected Health Information is being used or disclosed for the following Purpose: **To help identify the client's needs and strengths, assist in developing treatment recommendations, assist in screening of eligibility for services and to provide care coordination of intensive mental health services.**

Authorization Duration: This authorization will be in force and effect until: **Six (6) Months after Termination of Services.** At that time, this authorization to disclose this protected health information expires.

I understand that I have the **right to revoke this authorization, in writing**, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA 34, CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or re-disclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a third Party. (Check this box ONLY if the disclosing party will receive compensation or other benefits for using and disclosing this PHI). ☐

Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative:	Description of Personal Representative's Authority:

Names and Addresses

Department of Health

- ☐ **Developmental Disabilities Division**
  1250 Punchbowl Street, Suite 463, Honolulu HI 96813
- ☐ **Early Intervention Section**
  1350 South King Street Suite 200 Honolulu, Hawaii 96814
- ☐ **Alcohol and Drug Abuse Division**
  601 Kamokila Boulevard, Suite 360, Kapolei HI 96707

Juvenile Client Services Branch, Judiciary

- ☐ **Oahu – First Circuit**
  4675 Kapolei Parkway, Kapolei HI 96707-3272
- ☐ **Maui – Second Circuit**
  2145 Main Street, Wailuku HI 96793-1679
- ☐ **Hawaii – Third Circuit**
  777 Kilauea Avenue, Hilo HI 96720-4212
- ☐ **Kauai – Fifth Circuit**
  3970 Kaana Street, Lihue HI 96766

University of Hawaii

- ☐ **Department of Psychology**
  The Center for Cognitive Behavior Therapy (CCBT)
  2444 Dole Street, Krauss Hall 101, Honolulu, HI 96822
- ☐ **Department of Psychiatry**
  1356 Lusitana Street, 4th Floor, Honolulu, HI 96813

Department of Education

- ☐ **Honolulu District**
  4967 Kilauea Avenue, Honolulu HI 96816
- ☐ **Central District**
  1122 Mapunapuna Street, Suite 200, Honolulu Hi 96819
- ☐ **Leeward District**
  601 Kamokila Boulevard, Suite 418, Kapolei, HI 96707
- ☐ **Windward District**
  46-169 Kamehameha Highway, Kaneohe HI 96744
- ☐ **Hawaii District**
  75 Aupuni St. Room 203, Hilo HI 96720-4253
- ☐ **Kauai District**
  3060 Eiwa Street, Suite 305, Lihue, HI 96766
- ☐ **Maui District**
  54 High St, 4th Floor, Wailuku HI 96793

Department of Human Services

- ☐ **Child Welfare Services Branch**
  420 Waiakamilo Road, Honolulu HI 96817
- ☐ **Office of Youth Services**
  42-470 Kalanianaole Highway, Kailua HI 96734
- ☐ **Med-QUEST Division**
  601 Kamokila Blvd, Room 518, Kapolei, HI 96707

Providers

- ☐ **Alaka`i Na Keiki**
  1100 Alakea St, Honolulu, HI 96813
- ☐ **Aloha House**
  200 Ike Dr, Makawao, HI 96768
- ☐ **Benchmark Behavioral Health Services**
  2501 Waimano Home Rd, Pearl City, HI 96782
- ☐ **Bobby Benson Center (BBC)**
  56-660 Kamehameha Highway Kahuku, HI 96731
- ☐ **CARE Hawaii, Inc.**
  875 Waimanu St, Honolulu, HI 96813
- ☐ **Catholic Charities Hawaii (CCH)**
  1822 Keeaumoku Street Honolulu, HI 96822
- ☐ **Child & Family Service**
  91-1841 Fort Weaver Road Ewa Beach, HI 96706
- ☐ **Hale Kipa Inc.**
  615 Pi'ikoi Street, Suite 203 Honolulu, HI 96814
- ☐ **Hale `Opio Kauai, Inc.**
  2959 Umi St # 300, Lihue, HI 96766
- ☐ **Hawaii Behavioral Health (HBH)**
  1330 Ala Moana Boulevard Suite 1, Honolulu, HI 96814
- ☐ **Hina Mauka**
  45-845 Po'okela Street, Kaneohe, HI 96744
- ☐ **Maui Youth & Family Services**
  200 Ike Dr, Makawao, HI 96768
- ☐ **Parents and Children Together (PACT)**
  1485 Linapuni Street, Suite 105 Honolulu, HI 96819
- ☐ **Queen's Medical Center (QMC)**
  1301 Punchbowl Street Honolulu, HI 96813
- ☐ **Salvation Army**
  1786 Kinoole Street, Hilo, HI 96720
- ☐ **Sutter Health Pacific dba Kahi Mohala Behavioral Hospital**
  91-2301 Fort Weaver Road Ewa Beach, HI 96706
- ☐ **Waianae Coast Comprehensive Health Center-Hale Na'au Pono**
  86-226 Farrington Highway Waianae, HI 96792

Other

- ☐
- ☐
- ☐

Youth Name:	**Customer ID# (if known):**