Child & Adolescent Mental Health Division

Print & Mail Instructions
Application for CAMHD Services

Instructions

- Fill in as much of the application as you can.
- You only have to complete the "Authorization to Jointly Disclose Protected Health Information" (pages 3 & 4) if there are other people you would like us to get information from (like a doctor or therapist).
- Mail the application and attachments (copies only, please) to the Family Guidance Center that serves the area where youth's parent / caregiver / guardian lives.
- If you need help or have questions, call a Family Guidance Center – our friendly staff will be happy to assist you!

Family Guidance Center Addresses

HAWAII

East Hawaii Family Guidance Center
serves Laupahoehoe to Pahoa to Naalehu
88 Kanoelehua Ave. Suite B-107
Hilo, HI 96720
Phone: (808) 933-0610

West Hawaii Family Guidance Center
serves Paauilo to Hawi to Ocean View
65-1230 Mamalahoa Hwy. Suite A-1
Kamuela, HI 96743
Phone: (808) 887-8100

KAUAI

Kauai Family Guidance Center
3059 Umi St. Room A-014
Lihue, HI 96766
Phone: (808) 274-3883

MAUI, MOLOKAI & LANAI

Maui Family Guidance Center
270 Waiehu Beach Rd. Suite 213
Wailuku, HI 96793
Phone: (808) 243-1252

OAHU

Central Oahu Family Guidance Center – Kaneohe Office
serves Waimanalo to Sunset Beach
45-691 Keaahala Rd. Building E-141
Kaneohe, HI 96744
Phone: (808) 233-3770

Central Oahu Family Guidance Center – Pearl City Office
serves Fort Shafter to Waialua excluding Pearl City
860 4th St. Room 220
Pearl City, HI 96782
Phone: (808) 453-5900

Honolulu Family Guidance Center
serves Hawaii Kai to Kalihi
3627 Kilauea Ave. Room 401
Honolulu, HI 96816
Phone: (808) 733-9393

Leeward Oahu Family Guidance Center
serves Pearl City to Waianae
601 Kamokila Blvd. Suite 355
Kapolei, HI 96707
Phone: (808) 692-7700

Child & Adolescent Mental Health Division

Application for CAMHD Services

Youth Information

_____ _____ _____ ○Male ○Female
Legal Name (First Last) *Date of Birth* *Social Security Number* *Gender*

_____ _____ _____
Preferred Name *Gender Identity* *Preferred Language*

_____ _____
School *Grade*

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

Primary Insurance Plan

○Aloha Care ○HMSA ○Kaiser ○OHANA ○UHA ○Other: _____

_____ _____
Insurance ID *Primary Care Provider*

Secondary Insurance Plan

☐ No Secondary Insurance

○Aloha Care ○HMSA ○Kaiser ○OHANA ○UHA ○Other: _____

_____
Insurance ID

Background Questions

Has youth been evaluated for emotional or behavioral reasons before? ○Yes ○No ○I don't know

Why are you seeking mental health services?

How did you hear about CAMHD services?

☐ Brochure ☐ Child Welfare Service ☐ DOH Website ☐ Primary Care Provider ☐ Probation Officer ☐ School ☐ Therapist ☐ Other: _____

Primary Legal Guardian Information

_____ _____
Name *Preferred Language*

_____ _____ _____
Primary Phone Number *Secondary Phone Number* *Email*

_____ _____ _____ _____
Mailing Address *City* *State* *Zip Code*

_____ ☐ Same as Mailing Address _____ _____ _____
Home Address *City* *State* *Zip Code*

Relationship to youth: ○Mother ○Father ○Grandparent ○Aunt/Uncle ○Foster Parent ○CWS Social Worker ○Other: _____

Does this individual have the legal right to sign consents for this youth? ○Yes ○No

If not the biological or adoptive parent, please provide guardianship or power of attorney documentation.

Additional Guardian Information (complete only if there is more than one guardian or caregiver)

☐ No Additional Guardian

_____ _____
Name *Preferred Language*

_____ _____ _____
Primary Phone Number *Secondary Phone Number* *Email*

_____ _____ _____ _____
Mailing Address *City* *State* *Zip Code*

_____ ☐ Same as Mailing Address _____ _____ _____
Home Address *City* *State* *Zip Code*

Relationship to youth: ○Mother ○Father ○Grandparent ○Aunt/Uncle ○Foster Parent ○CWS Social Worker ○Other: _____

Does this individual have the legal right to sign consents for this youth? ○Yes ○No

If not the biological or adoptive parent, please provide guardianship or power of attorney documentation.

Referring Agency Information (completed by referring agency) ☐ No Referring Agency

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

_____ _____ _____ _____
Name *Title* *Phone Number* *Email*

_____ _____ _____ _____
Mailing Address *City* *State* *Zip Code*

Relationship to youth: ○CWS Social Worker ○DOE/SBBH ○Foster Parent ○Probation Officer ○Other: _____

Do you have the legal right to sign consents for this youth? ○Yes ○No

Do you have the legal right to send and receive information about this youth (signed authorization on file)? ○Yes ○No

Reason for application:

Youth's social, emotional, and behavioral health needs:

CWS / HYCF / Probation / Parole Details

_____ _____ _____
CWS Start Date *Projected CWS End Date* *CWS Status*

_____ _____ _____ _____ _____ _____
HYCF Start Date *Projected HYCF End Date* *Probation Start Date* *Projected Probation End Date* *Parole Start Date* *Projected Parole End Date*

DOE / SBBH Details

Placement: ○Regular Ed ○Resource ○FSC ○Other: _____

Has youth's IEP team determined youth is in need of intensive mental health services in order to benefit from their education? ○Yes ○No ○N/A

Emotional Behavioral Assessment or Other Clinical Diagnostic Assessment Details (required for applications from DOE)

_____ _____ _____
Assessment Completed By *Assessment Date* *Diagnosis*

Is youth on medication? ○Yes ○No Prescriber: _____

_____ _____ _____
Medication & Dose *Medication & Dose* *Medication & Dose*

Additional information / notes:

Attachments (applications submitted without required items will not be processed until items are received by the Family Guidance Center)

☐ Guardianship or Power of Attorney Documents (required if Legal Guardian is not youth's biological or adoptive parent)

☐ Evaluation or Assessment (required for applications from DOE) ☐ Individualized Education Program or 504 Modification Plan

☐ Other: _____ ☐ Other: _____

Acknowledgement (if you do not have the legal right to sign consents for this youth, application will not be processed until Legal Guardian's signature is obtained)

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

I hereby consent to the evaluation of this youth for the purpose of determining eligibility, and agree to CAMHD program enrollment, and agree that CAMHD may obtain information about this youth with the understanding that it cannot be disclosed to others (except referring agency, if applicable) without my further approval, unless permitted by Federal or State law.

I also understand that this consent expires in one (1) year.

_____ _____ _____
Parent / Legal Guardian Signature *Date* *Relationship to Youth*

Child & Adolescent Mental Health Division

Authorization to Jointly Disclose Protected Health Information (PHI)

Individual Whose Protected Health Information is Being Disclosed

Name (First Last)	Date of Birth	Address

Parties Requesting and/or Disclosing Information

From: **Child & Adolescent Mental Health Division**
3627 Kilauea Avenue, Room 101, Honolulu HI 96816

To: **All Parties Identified Below**
(identify all parties to whom information may be disclosed)

From: **All Parties Identified Below**
(identify all parties from whom information may be disclosed)

To: **Child & Adolescent Mental Health Division**
3627 Kilauea Avenue, Room 101, Honolulu HI 96816

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

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

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

University of Hawaii
- ☐ Dept. of Psychology (Eval/CCBT)
- ☐ Dept. of Psychiatry (Eval/Telepsych)

Department of Education
- ☐ Honolulu District
- ☐ Central District
- ☐ Leeward District
- ☐ Windward District
- ☐ Hawaii District
- ☐ Kauai District
- ☐ Maui District

Other
- ☐
- ☐
- ☐
- ☐
- ☐

Providers
- ☐ Alaka'i Na Keiki
- ☐ Aloha House
- ☐ Benchmark Behavioral Health Services
- ☐ Bobby Benson Center
- ☐ Care Hawaii, Inc
- ☐ Catholic Charities Hawaii
- ☐ Child & Family Service
- ☐ Hale Kipa, Inc.
- ☐ Hale 'Opio Kauai, Inc.
- ☐ Hawaii Behavioral Health
- ☐ Hina Mauka
- ☐ Maui Youth & Family Services
- ☐ Parents and Children Together
- ☐ Sutter Health dba Kahi Mohala
- ☐ Waianae Coast CMHC - Hale Na'au Pono

Types of Information to be 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 (CMP), Coordinated Service Plans (CSP), Mental Health-related assessments and evaluations
- Individualized Educational Plans (IEP) and Department of Education (DOE) health-related documents
- Provider Mental Health Treatment Plans (MHTP) and progress reports
- Functional Behavioral Assessments and Behavioral Support Plans
- Court hearings, reports and orders
- Mental Health-related medical records
- Department of Human Services (DHS) reports
- _____
- _____

Specially Protected Information: This Authorization includes the disclosure of **Substance Abuse Treatment** information. _____

Purpose: To help identify the client's needs and strengths, assist in developing treatment recommendations, assist in determining eligibility for services and to provide care coordination of intensive mental health services.

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

Acknowledgement of Authorizing Individual or Personal Representative

I understand 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 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 the information 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 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 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 benefit when using or disclosing this Protected Health Information)

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

Names and Addresses

Department of Health

☐ Alcohol and Drug Abuse Division
601 Kamokila Boulevard, Suite 360, Kapolei HI 96707

☐ Developmental Disabilities Division
1250 Punchbowl Street, Suite 423, Honolulu HI 96813

☐ Early Intervention Section
1350 South King Street, Suite 200, Honolulu HI 96814

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 Boulevard, Room 518, Kapolei HI 96707

Juvenile Client Services Branch

☐ Oahu – First Circuit
4675 Kapolei Parkway, Kapolei HI 96707

☐ Maui – Second Circuit
2145 Main Street, Wailuku HI 96793

☐ Hawaii – Third Circuit
777 Kilauea Avenue, Hilo HI 96720

☐ Kauai – Fifth Circuit
3970 Kaana Street, Lihue HI 96766

University of Hawaii

☐ Dept. of Psychology (Eval/CCBT)
2444 Dole Street, Krauss Hall 101, Honolulu HI 96822

☐ Dept. of Psychiatry (Telepsych/Eval)
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 Street, Room 203, Hilo HI 96720

☐ Kauai District
3060 Eiwa Street, Suite 305, Lihue HI 96766

☐ Maui District
54 High Street, 4th Floor, Wailuku HI 96793

Providers

☐ Alaka'i Na Keiki
1100 Alakea Street, Honolulu HI 96813

☐ Aloha House
200 Ike Drive, Makawao HI 96768

☐ Benchmark Behavioral Health Services
2501 Waimano Home Road, Pearl City HI 96782

☐ Bobby Benson Center
56-660 Kamehameha Highway, Kahuku HI 96731

☐ Care Hawaii, Inc
875 Waimanu Street, Honolulu HI 96813

☐ Catholic Charities Hawaii
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 Street, #300, Lihue HI 96766

☐ Hawaii Behavioral Health
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 Drive, Makawao HI 96768

☐ Parents and Children Together
1300 Halona Street, Honolulu HI 96817

☐ Sutter Health dba Kahi Mohala
91-2301 Fort Weaver Road, Ewa Beach HI 96706

☐ Waianae Coast CMHC - Hale Na'au Pono
86-226 Farrington Highway, Waianae HI 96792

Other

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