



## Instructions

- Fill in as much of the application as you can.
- You only have to complete the “Authorization to Jointly Disclose Protected Health Information” 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

### HAWAI‘I

#### East Hawai‘i Family Guidance Center

*serves Laupāhoehoe to Pāhoia to Nā‘ālehu*

88 Kanoelehua Ave. Suite B-107

Hilo, HI 96720

Phone: (808) 933-0610

#### West Hawai‘i Family Guidance Center

*serves Pa‘auilo to Hawi to Ocean View*

75-5722 Kuakini Hwy. Suite 201

Kailua-Kona, HI 96740

Phone: (808) 491-9226

### KAUA‘I

#### Kaua‘i Family Guidance Center

3059 Umi St. Room A-014

Līhu‘e, HI 96766

Phone: (808) 274-3883

### MAUI, MOLOKA‘I & LĀNA‘I

#### Maui Family Guidance Center

270 Waiehu Beach Rd. Suite 213

Wailuku, HI 96793

Phone: (808) 243-1252

### O‘AHU

#### Central O‘ahu Family Guidance Center – Kaneohe Office

*serves Waimānalo to Sunset Beach*

45-691 Keaahala Rd. Building E-141

Kāne‘ohe, HI 96744

Phone: (808) 233-3770

#### Central O‘ahu 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 Hawai‘i Kai to Kalihi*

3627 Kīlauea Ave. Room 401

Honolulu, HI 96816

Phone: (808) 733-9393

#### Leeward O‘ahu Family Guidance Center

*serves Pearl City to Wai‘anae*

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*

\_\_\_\_\_  
*Home Address*  Same as Mailing 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*

\_\_\_\_\_  
*Home Address*  Same as Mailing 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.

# Application for CAMHD Services

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

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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

<p><b>Department of Health</b></p> <input type="checkbox"/> Alcohol and Drug Abuse Division <input type="checkbox"/> Developmental Disabilities Division <input type="checkbox"/> Early Intervention Section	<p><b>Department of Education</b></p> <input type="checkbox"/> Honolulu District <input type="checkbox"/> Central District <input type="checkbox"/> Leeward District <input type="checkbox"/> Windward District <input type="checkbox"/> Hawai'i District <input type="checkbox"/> Kaua'i District <input type="checkbox"/> Maui District	<p><b>Providers</b></p> <input type="checkbox"/> Aloha House <input type="checkbox"/> Benchmark Behavioral Health System <input type="checkbox"/> Bobby Benson Center <input type="checkbox"/> CARE Hawai'i <input type="checkbox"/> Catholic Charities Hawai'i <input type="checkbox"/> Child & Family Service <input type="checkbox"/> EPIC 'Ohana <input type="checkbox"/> Hale Kipa <input type="checkbox"/> Hale 'Opio Kaua'i <input type="checkbox"/> Hawai'i Behavioral Health <input type="checkbox"/> Hina Mauka <input type="checkbox"/> Ho'ola Nā Pua – Pearl Haven <input type="checkbox"/> Maui Youth & Family Services <input type="checkbox"/> Parents and Children Together <input type="checkbox"/> Queen's Medical Center – Kāhi Mōhala <input type="checkbox"/> Wai'anae Coast CMHC – Hale Na'au Pono
<p><b>Department of Human Services</b></p> <input type="checkbox"/> Child Welfare Services Branch <input type="checkbox"/> Office of Youth Services <input type="checkbox"/> Med-QUEST Division	<p><b>Juvenile Client Services Branch</b></p> <input type="checkbox"/> O'ahu – First Circuit <input type="checkbox"/> Maui – Second Circuit <input type="checkbox"/> Hawai'i – Third Circuit <input type="checkbox"/> Kaua'i – Fifth Circuit	
<p><b>University of Hawai'i</b></p> <input type="checkbox"/> Dept. of Psychology (Eval/CCBT) <input type="checkbox"/> Dept. of Psychiatry (Eval/Telepsych)	<p><b>Other</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

*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
- Provider Mental Health Treatment Plans (MHTP) and progress reports
- Court hearings, reports and orders
- Individualized Educational Plans (IEP) and Department of Education (DOE) health-related documents
- Functional Behavioral Assessments and Behavioral Support Plans
- 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)

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

## CAMHD Authorization to Jointly Disclose Protected Health Information (PHI)

Names and Addresses	
<p><b>Department of Health</b></p> <p><input type="checkbox"/> Alcohol and Drug Abuse Division 601 Kamokila Boulevard, Suite 360, Kapolei HI 96707</p> <p><input type="checkbox"/> Developmental Disabilities Division 1250 Punchbowl Street, Room 463, Honolulu HI 96813</p> <p><input type="checkbox"/> Early Intervention Section 1010 Richards Street, Suite 811, Honolulu HI 96813</p> <p><b>Department of Human Services</b></p> <p><input type="checkbox"/> Child Welfare Services Branch 420 Waiakamilo Road, Honolulu HI 96817</p> <p><input type="checkbox"/> Office of Youth Services 42-470 Kalaniana'ole Highway, Kailua HI 96734</p> <p><input type="checkbox"/> Med-QUEST Division 601 Kamokila Boulevard, Room 415, Kapolei HI 96707</p> <p><b>Juvenile Client Services Branch</b></p> <p><input type="checkbox"/> O'ahu – First Circuit 4675 Kapolei Parkway, Kapolei HI 96707</p> <p><input type="checkbox"/> Maui – Second Circuit 2145 Main Street, Wailuku HI 96793</p> <p><input type="checkbox"/> Hawai'i – Third Circuit 777 Kīlauea Avenue, Hilo HI 96720</p> <p><input type="checkbox"/> Kaua'i – Fifth Circuit 3970 Kā'ana Street, Līhu'e HI 96766</p> <p><b>University of Hawai'i</b></p> <p><input type="checkbox"/> Dept. of Psychology (Eval/CCBT) 2444 Dole Street, Krauss Hall 101, Honolulu HI 96822</p> <p><input type="checkbox"/> Dept. of Psychiatry (Telepsych/Eval) 651 Ilalo Street, Honolulu HI 96813</p> <p><b>Department of Education</b></p> <p><input type="checkbox"/> Honolulu District 4967 Kīlauea Avenue, Honolulu HI 96816</p> <p><input type="checkbox"/> Central District 1122 Māpunapuna Street, Suite 200, Honolulu HI 96819</p> <p><input type="checkbox"/> Leeward District 601 Kamokila Boulevard, Suite 588, Kapolei HI 96707</p> <p><input type="checkbox"/> Windward District 46-169 Kamehameha Highway, Kāne'ohe HI 96744</p> <p><input type="checkbox"/> Hawai'i District 75 'Apuni Street, Room 203, Hilo HI 96720</p> <p><input type="checkbox"/> Kaua'i District 3060 'Eiwa Street, Līhu'e HI 96766</p> <p><input type="checkbox"/> Maui District 54 High Street, 4th Floor, Wailuku HI 96793</p>	<p><b>Providers</b></p> <p><input type="checkbox"/> Aloha House 200 Ike Drive, Makawao HI 96768</p> <p><input type="checkbox"/> Benchmark Behavioral Health System 2501 Waimano Home Road, Pearl City HI 96782</p> <p><input type="checkbox"/> Bobby Benson Center 56-660 Kamehameha Highway, Kahuku HI 96731</p> <p><input type="checkbox"/> CARE Hawai'i 1345 S. Beretania Street, Suite 301, Honolulu HI 96814</p> <p><input type="checkbox"/> Catholic Charities Hawai'i 1822 Ke'eaumoku Street, Honolulu HI 96822</p> <p><input type="checkbox"/> Child &amp; Family Service 91-1841 Fort Weaver Road, 'Ewa Beach HI 96706</p> <p><input type="checkbox"/> EPIC 'Ohana 1130 N. Nimitz Highway, Suite C-210, Honolulu HI 96817</p> <p><input type="checkbox"/> Hale Kipa 91-2128 Old Fort Weaver Road, 'Ewa Beach HI 96706</p> <p><input type="checkbox"/> Hale 'Ōpio Kaua'i 2959 Umi Street, #300, Līhu'e HI 96766</p> <p><input type="checkbox"/> Hawai'i Behavioral Health 1330 Ala Moana Boulevard, Suite 1, Honolulu HI 96814</p> <p><input type="checkbox"/> Hina Mauka 45-845 Po'okela Street, Kāne'ohe HI 96744</p> <p><input type="checkbox"/> Ho'ōla Nā Pua – Pearl Haven PO Box 22551, Honolulu HI 96823</p> <p><input type="checkbox"/> Maui Youth &amp; Family Services 200 Ike Drive, Makawao HI 96768</p> <p><input type="checkbox"/> Parents and Children Together 1300 Hālonā Street, Honolulu HI 96817</p> <p><input type="checkbox"/> Queen's Medical Center – Kāhi Mōhala 91-2301 Fort Weaver Road, 'Ewa Beach HI 96706</p> <p><input type="checkbox"/> Wai'anae Coast CMHC – Hale Na'au Pono 86-226 Farrington Highway, Wai'anae HI 96792</p> <p><b>Other</b></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>