The Arc Monroe New York

Referral Application

Person Requesting Services		
	Legal Name:	Sex: Gender:
	Name/Pronouns:	Social Security #:
	Address:	Date of Birth:
	City, Zip:	TABS ID Number:
	Certified Residence: ☐ Yes ☐ No	Medicaid ID Number:
	Phone Number:	Monroe County? ☐ Yes ☐ No
	Waiver Enrolled? ☐ Yes ☐ No	HCBS Waiver NOD Date:
	Self-Directing Services? ☐ Yes ☐ No	
	Fiscal Intermediary (FI):	Broker:

Emergency Contact		
	Name:	Phone:
	Address:	Legal Guardian? ☐ Yes ☐ No
	Email:	

Service Requested		
	☐ **Community Habilitation** ☐ **Group Day Habilitation** ☐ **Community Prevocational** ☐ **Recreation-Respite** ☐ **FSS- Behavior Management** ☐ **Residential Habilitation**	
	Aging out of current program/service? ☐ Yes ☐ No	Date Service(s) needed:
	Current Daytime Activity?	
	Reason for Service Request:	

Clinical Supports	
	Currently Receiving: ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech/Language Therapy ☐ Counseling ☐ Psychiatry ☐ Nutrition
	Unmet Need/Interested in Receiving: ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech/Language Therapy ☐ Counseling ☐ Psychiatry ☐ Nutrition ☐ Psychological Evaluations

Referral Source		
	Name:	Title/Agency:
	Phone:	Email:
	Address:	
	Best way to contact:	
	How did you hear about us? ☐ From a Friend ☐Website ☐TV ☐Social Media ☐Internet Search ☐Tour ☐Other	

Requested Documents Checklist

Please use the checklist specific to the service(s) requested and attach documents accordingly

		The Arc Monroe New York	Group Day Habilitation	Residential Habilitation	Community Habilitation	FSS-Behavior Management	Community Prevocational	Recreation-Respite
Required Documents	Chicken Pox/Varicella Immunization							
	RHIO Consent Form							
	OPWDD Service Authorization (NOD)							
	DDP-2 **(within 2 years)**							
	HCBS Wavier NOD							
	Life Plan/IPOP/Safeguards/SAP							
	LCED **(within 1 year)**							
	Physical and Current Medication List **(within 1 year)**							
	PPD/TB Test **(within 1 year)**							
	Psychological Evaluation							
	Social History							
Service Specific	Specific Program Addendum **(see website for additional form)**							
	Income Verification							
	Community Based Workplace Assessment/DVE							
	Medicaid Award Letter							
	OPWDD Eligibility Award Letter							
Person Specific	Current Behavior Plan/Guidelines/Medication Monitoring Plan							
	DDRO At-Risk Assessment							
	Individualized Education Plan (IEP)							
	Legal Guardian Paperwork							
	Other Clinical Evaluations							
	Psychiatric Evaluation							

Completed referrals may be mailed to:

Attention: Community Outreach & Enrollment
The Arc of Monroe
2060 Brighton Henrietta Townline Road
Rochester, NY 14623

Note: This referral may be revoked at any time by putting such request in writing and submitting to the manager of Outreach and Enrollment

Office Use Only
Date Received: Date Processed:
Revision Level – 1 Initials:

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: Monroe County Chapter, NYSARC, Inc. (DBA: Arc of Monroe)

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _ ; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

AFFORDABLE CARE ACT NON-DISCRIMININATION NOTICE: ENGLISH

The Arc of Monroe County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Arc of Monroe County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Arc of Monroe County:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact please contact the director of your program or service.

If you believe that The Arc of Monroe County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Deanna Crosser, Quality Improvement Director, The Arc of Monroe County, 2060 Brighton-Henrietta Townline Road, Rochester, NY 14623, 585-271-0660 x1685, Fax: 585-672-2230, email: dcrosser@arcmonroe.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Deanna Crosser is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

AFFORDABLE CARE ACT NON-DISCRIMININATION NOTICE: ESPAÑOL

The Arc of Monroe County cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. The Arc of Monroe County no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

The Arc of Monroe County:
Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
Intérpretes de lenguaje de señas capacitados.

- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:

- Intérpretes capacitados.
- Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Deanna Crosser, Quality Improvement Director: 585-271-0660 x1685.

Si considera que The Arc of Monroe County no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Deanna Crosser, Quality Improvement Director, The Arc of Monroe County, 2060 Brighton-Henrietta Townline Road, Rochester, NY 14623, 585-271-0660 x1685, Fax: 585-672-2230, Email: dcrosser@arcmonroe.org. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo. Deanna Crosser, Quality Improvement Director está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

V1 916

Affordable Care Act Non-Discrimination Language Support

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-866-946-9733

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-946-9733

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-946-9733

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-946-9733。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-946-9733

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-946-9733

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-946-9733 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-946-9733

לאצפא וופ יירפ סעסיוורעס קליה דארפש דייא ראפ ואהראפ וענעז ,שידיא טדער ריא ביוא :מאזקרעמפיוא.
טפור 1-866-946-9733

ল্য় করনঃ যিদ আপিন বাংলা, কথা বলেত পাের্ন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল্ অোছ।
ের্ফান করন 1-866-946-9733 ।

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك - 1-866-946-9733
بالمجان. اتصل برقم

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-946-9733

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں
دستیاب ہیں ۔ کال
1-866-946-9733 کریں

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-946-9733.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-946-9733.