

**YORK/ADAMS HEALTHCHOICES MANAGEMENT UNIT
CHILDREN AND ADOLESCENT SUPPORT SERVICES
APPLICATION REQUEST**

Applicant Name: _____
M.A. #: _____
Behavioral Health Diagnosis: _____

Current Services: _____

County of Residence: York Adams
Application Date: _____

Service Requested

Please select **one** service and attach additional documentation as required.

- | | |
|--|---|
| <input type="checkbox"/> Respite (Routine = or > 24 hours notice) | <input type="checkbox"/> Respite (Emergent < 24 hours notice) |
| <input type="checkbox"/> Parenting Support Services | <input type="checkbox"/> Crisis Nursery Services |
| <input type="checkbox"/> CRR Host Home Room & Board * | <input type="checkbox"/> Shelter Care (MH Kids Only)*** |
| <input type="checkbox"/> Case Management (Family Support & Advocacy Service)** | |
| <input type="checkbox"/> Residential Diagnostic Services *** | |
| <input type="checkbox"/> Other Service - (Specify): _____ | |

* **County liability required by family and referral source verification of child's SSI/SSDI benefit.**

** This service is available only to those families accessing Crisis Nursery Services and recommended by Children's Aid Society at The Lehman Center. This service must demonstrate it does not duplicate other case management.

*** Recent clinical information must accompany application & HCMU approval is based upon appropriate need for level of service. Supporting documentation regarding the potential outcomes desired in using this service must be attached.

Support or Service Provider

Service Provider/Vendor: _____
Address of Provider/Vendor: _____
Contact Person Name: _____
Contact Phone/Fax/Email: _____

Start Date: _____
End Date: _____
No. of Units: _____
Unit Cost: _____
Total Amount Requested: _____

<u>*If CRR Host Home Request:</u>
SSI/SSDI Amount: _____
County Liability: _____
Length of Treatment
approved by CCBH: _____

Referral Name/Title: _____
Referral Agency: _____
Referral Contact #: _____
Referral Email Address: _____

PLEASE SUBMIT COMPLETED REQUEST TO:

York/Adams HealthChoices Management Unit
 Attn: Connie Livingston 100 W. Market Street, Suite B-03, York, PA 17401-1332
 717-771-9900 (office) 717-771-9590 (fax) cjlivingston@york-county.org (email)



**YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM**

- | | | |
|---|---|---|
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Children/Youth Services | <input type="checkbox"/> Community Service |
| <input type="checkbox"/> HealthChoices | <input type="checkbox"/> Youth Development Center | <input type="checkbox"/> Human Services Department |
| <input type="checkbox"/> Drug/Alcohol Program | <input type="checkbox"/> Veterans Affairs | <input type="checkbox"/> Mental Health/Mental Retardation Program |

I hereby authorize (Name of Referral Source) _____ to release information to and/or receive information from **HealthChoices Management Unit** regarding the record of:

Name: _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

The information released will be limited to the following: **The clinical and financial information needed for the purposes of making a decision on any Children and Adolescent Support Services Application.**

The information will be used for the following purpose(s): **For determining Children and Adolescent Support Services Program eligibility.**

This release is valid from (start) _____ to (end) _____ and may be revoked at any time, except to the extent that action has already been taken based on this authorization. To revoke this authorization, please notify, in writing, the York County Human Services Agency identified above. I understand that I need not consent to the release of this information. However, I choose to do so voluntarily. I understand that treatment, payment, enrollment or eligibility are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services. I understand that there may be a risk that the person/organization receiving my information could possibly re-disclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I understand what it means.

Signature of client/parent/guardian (Relationship) _____ Date _____

Signature of Staff Person _____ Date _____

VERBAL RELEASE INFORMATION:

This section is to be used for clients who are unable to provide a signature.

We have witnessed that the client understands the nature of this release and has freely given his/her consent.

Witness _____ Date _____

Witness _____ Date _____

Notice to the recipient of these records: This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.

Please provide a copy of the signed release to the individual requesting the release.



**YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM**

- | | | |
|---|---|---|
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Children/Youth Services | <input type="checkbox"/> Community Service |
| <input type="checkbox"/> HealthChoices | <input type="checkbox"/> Youth Development Center | <input type="checkbox"/> Human Services Department |
| <input type="checkbox"/> Drug/Alcohol Program | <input type="checkbox"/> Veterans Affairs | <input type="checkbox"/> Mental Health/Mental Retardation Program |

I hereby authorize **HealthChoices Management Unit** to release information to and/or receive information from

(Name of Vendor/Payee) _____ regarding the record of:

Name: _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

The information released will be limited to the following: **Verification of payment for requested service or support under the HealthChoices Children and Adolescent Support Services program.**

The information will be used for the following purpose(s): **Confirming the need for the requested payment and verification of billing information.**

This release is valid from (start) _____ to (end) _____ and may be revoked at any time, except to the extent that action has already been taken based on this authorization. To revoke this authorization, please notify, in writing, the York County Human Services Agency identified above. I understand that I need not consent to the release of this information. However, I choose to do so voluntarily. I understand that treatment, payment, enrollment or eligibility are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services. I understand that there may be a risk that the person/organization receiving my information could possibly re-disclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I understand what it means.

Signature of client/parent/guardian (Relationship) _____ Date

Signature of Staff Person _____ Date

VERBAL RELEASE INFORMATION:

This section is to be used for clients who are unable to provide a signature.

We have witnessed that the client understands the nature of this release and has freely given his/her consent.

Witness _____ Date

Witness _____ Date

Notice to the recipient of these records: This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.

Please provide a copy of the signed release to the individual requesting the release.

**Children and Adolescent Support Services Program
Financial Resource Evaluation Worksheet**

Use MONTHLY Average

Applicant's Name:

of People Living in Household:

Date Completed:

MONTHLY Income and Expenses:		Asset Evaluation	
Income (family)		Savings	
Earnings (net)		Investments	
SSI		Capital Equity (net)	
SSDI		Total Assets	
Child Support		Total Assets Available to Utilize:	
Food Stamps			
Other			
Total Income			
Expenses		<u>Additional Comments:</u>	
Rent/Mortgage			
Real Estate Taxes			
School Taxes			
Utility Gas			
Utility Electric			
Utility Water			
Utility Telephone and/or Cell Phone			
Utility Cable TV			
Utility Internet Services			
Utility - Sewer, trash collection, etc.			
Clothing			
Food/Groceries (minus food stamps)			
Auto payment (# of vehicles ____)			
Auto repairs/maintenance			
Auto insurance			
Auto - gas			
Insurances (other)			
Medications / Health Care			
Credit card (consumer debt pay)			
Entertainment Expenses			
Other expenses: Please specify...			
Total Expenses:			
Total Income minus Expenses:			