HealthPlan OF SAN MATEO
Healthy is for everyone

Magellan HEALTHCARE

Applied Behavioral Analysis (ABA) Screening Form

Referral form can be submitted by FAX at **888-656-3847**
or by email at **MagellanSanMateoReferrals@magellanhealth.com**

Patient Name: _____

DOB: _____ **Language:** _____

Name of Referring Provider: _____

Email: _____ **Phone:** _____

Please indicate which types of documentation you have reviewed: (select all that apply)

- ☐ Recent treatment plan from patient's ABA provider
- ☐ Individual Education Plan (IEP) with diagnostic testing detailed
- ☐ Diagnostic report
- ☐ Diagnostic report from a licensed professional (PhD, PsyD, MD), created more than 24 months ago
- ☐ Diagnostic report from a non-licensed professional, any time period

Please indicate any concerns expressed by the parent during interview: (select all that apply)

- ☐ Lack of expressive communication
- ☐ Poor eye contact
- ☐ Self-stimulatory behaviors (i.e. rocking back and forth, hand flapping, humming, etc.)
- ☐ Self-injurious behaviors (i.e. biting self, hitting self, etc.)
- ☐ Elopement (running away from home/parent)
- ☐ Non-compliance
- ☐ Excessive crying/whining/tantrums (outside of age normative levels)

Please include the following documentation with referral form:

- ☑ Any comprehensive diagnostic evaluation that took place in the last 2 years
- ☑ Authorization of disclosure signed by parent/guardian in order for Magellan to discuss the case with the referring provider

After review of the patient documentation and parent interview the following have been confirmed: (select one)

- ○ **Diagnosis of Autism and a recommendation of ABA (Attach report)**
- ○ **Diagnosis of Autism and no recommendation of ABA**
  Other services that are more appropriate are: _____
- ○ **CDE needed to determine if member has Autism**
- ○ **Diagnosis of _____ and recommendation for Parent-Caregiver Behavior Training (Short Term)**
- ○ **No diagnosis of Autism; follow up testing to rule out**
  Other mental/behavioral health concerns: _____

Name (print)	Signature	Date Signed

IMPORTANT: Can you read this? If not, we can have somebody help you read it. For free help, please call your Magellan program toll-free number.

IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame al número gratuito del programa.

Last Update: 02/2017

Consent to Release Protected Health Information (PHI)

Magellan Health, Inc.
P.O. Box 719002
San Diego, CA 92171
Managing Care for
Health Plan San Mateo 800-424-4134

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors or Health Plan San Mateo your PHI unless you say it is **OK**. By signing this paper, you give us your **OK.** We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call Magellan Health, Inc. (Magellan) at 800-424-4134**.**

Part 1 Who is the patient?

Last Name	First Name	Middle Initial

ID Number	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)

Address	City	State	Zip Code

Check One

☐ I am the patient OR

☐ I have the legal right to act for this person. (Check one below; if "other" fill in blank)

I'm his or her: ☐ Parent OR ☐ Guardian, OR ☐ Other _____

Part 2 Who can give out the PHI?

Magellan may give out your PHI. Magellan manages your mental health and/or drug and alcohol treatment for [Insert Account Name].

Part 3 Who can the PHI be given to?

Name (a person, like family members who live with me, or a place of business):	Phone Number (with area code)

Address:	City, State, and Zip Code

Part 4 What PHI can we share?

We will **only** share the PHI that you **OK.** This **OK** includes facts about your medicine. It also includes facts about your mental health and/or your alcohol and drug treatment that are in your records. It does not cover psychotherapy notes that <u>are not</u> in your medical records. Tell us the health information from your records that can be shared. Give the date or place if you can.

_____

_____

If you give us your OK to share <u>this</u> kind of health information, tell us by checking the box.

☐ HIV/AIDS ☐ Alcohol/Substance Abuse Records ☐ Sexual/Physical/Mental Abuse

Part 5 Why are you giving out this PHI?

Tell us why you want us to share your PHI?_____

_____

Turn this page over.

Part 6 When does my OK end?

Your **OK** will end when you tell us it does. **Tell us when you want your OK to end:**

☐ **My OK ends on this date** (It cannot be more than one year from your **OK**)

OR

☐ **My OK ends when this happens:** _____

(It can be something like "you can share my medical records this one time.") If you do not tell us when your **OK** ends then we will end your **OK** in one year from when you sign. After one year, we will need a new **OK.**

Part 7 Your Rights and Important Facts

- Giving your **OK** is up to you. You do not have to share your information.
- You do not have to **OK** this paper. You will still get benefits and treatment.
- You can take back your **OK.** You must tell us in writing. Mail it to Magellan Health, Inc., Attn: Compliance Officer P.O. Box 719002 San Diego, CA 92171.
- What if you take back your **OK?** This will not take back the PHI that we have already shared. But, we **will not** share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed **OK.** If you need another copy, call Magellan at 800-424-4134**.**
- If you do not understand, or have questions, we can help. Call Magellan at 800-424-4134.

Part 8 Signature of Patient

I give my **OK** to share the information listed in this paper.

_____ _____

Signature or Mark of Patient Date

Part 9 Signature of Authorized Representative (if any)

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor.

_____ _____

Signature of Person signing on behalf of patient Date

Printed Name: _____ Phone: _____

Address: _____

You should get a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your address and date of birth. A full definition of PHI is at 45 CFR §160.103.

NOTICE TO ANYONE OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.