FRANNIE PEABODY
CENTER
Comprehensive HIV & AIDS Services

Dear Provider,

Thank you for making a referral to case management services at Frannie Peabody Center. By completing this referral packet, you will allow us to expeditiously begin the process of enrollment in case management services. Once the referral is made, the client will be contacted by a case manager to schedule an intake appointment.

Please include:

- A copy of client's most recent CD4 and viral load lab results
- Verification of HIV Status form
- Request for Case Management Services form
- Acuity Scale for Provider Referrals
- A signed release of information in order for Frannie Peabody Center to follow up with you about this referral.
- Any additional releases that may help us connect with this client (i.e. for Optimal Interpreter services if client has English as a second language, etc).

This information can be faxed to 207-879-0761 or send by mail to:

Case Management
Frannie Peabody Center
30 Danforth St, Suite 309
Portland, ME, 04101

If you have any questions about these forms or our services in general, please do not hesitate to contact Charlotte Rogers, Case Management Supervisor at 207-749-5163.

Sincerely,

Frannie Peabody Center Case Management Team

FRANNIE PEABODY CENTER
Comprehensive HIV & AIDS Services

Acuity Scale for Provider Referrals

Frannie Peabody Center Case Management Services can assist our clients with the following areas of need. Please indicate the current level of need for each area to the best of your ability. This will enable us to assign the client to the appropriate caseload.

Area	Client identifies no needs in this area	Client identifies low needs in this area	Client identifies moderate needs in this area	Client identifies high needs in this area	Client is in crisis in this area
1. Access					
2. Housing					
3. Food/Nutrition					
4. Transportation/Home Care					
5. Education/Employment/Financial Support					
6. Treatment Adherence					
7. Dental Care					
8. Mental Health/Social Support					
9. Substance Use					
10. Relationships					
11. Legal					
12. Other					

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Request for Case Management Services

CM Assigned:	Staff	Date:
	Referral Source:	Release? ☐Yes ☐No

Name/Pronouns:	**DOB** (if under 19 needs prior approval):
Address:	**Phone:**
OK to send mail from de-identified PO Box regarding services/coordinate intake if not reachable by phone? ☐Yes ☐No	Ok to leave message on phone? ☐Yes ☐No **interpretations svs?** _____ language needed

Referral Questions	YES	NO	Comments
Newly Diagnosed? (Diagnosed when? Where?)	☐	☐	
In medical care? (Who? HIV or Primary Care?)	☐	☐	
On HIV medications? (How many days' supply?)	☐	☐	
Safely housed? (Housing status details)	☐	☐	
Health insurance? (Who is insurer?)	☐	☐	
ADAP?	☐	☐	
Income eligible? (What is annual income?) (Employed?)	☐	☐	

Kepro Dates of Registration:

Comments: *Family status? Immigration status? Transportation needs? Urgent needs?*	**For Follow-Up Notes ONLY: Documented attempts to contact**

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VERIFICATION OF HIV STATUS

Patient Name: _____ Date of Birth: _____

Patient has been diagnosed with HIV (not AIDS)	☐ Yes ☐ No
Date of HIV diagnosis:	
Patient has been diagnosed with AIDS, consistent with diagnostic criteria established by the US CDC	☐ Yes ☐ No
Date of AIDS diagnosis:	
Patient has been diagnosed with Hepatitis B	☐ Yes ☐ No
Patient has been diagnosed with Hepatitis C	☐ Yes ☐ No

Physician's Name (please print) Date

Physician's Signature Date

This information is necessary in order for us to serve your patient. Please return as soon as possible to:

Frannie Peabody Center
Attn: Case Management 30
Danforth Street, Suite 309
Portland, ME 04101
Fax: (207) 879-0761

FRANNIE PEABODY CENTER
Release/Authorization to Use/Disclose Confidential Information

I authorize Frannie Peabody Center and their authorized employees to:

Client Name: _____

Date of Birth: _____ File #: _____

(Check one below)

☐ **Both Release information to and Obtain from**

☐ **Release information to**

☐ **Obtain information from**

Name: _____

Street: _____

City: _____

State/Zip: _____

Intent/Purpose of this authorization:

Share the following information (check those that apply):

☐ Medical, Medication, Labs and Test Results ☐ Housing information ☐ Income and Financial status

☐ Other:_____

I DO authorize the disclosure of information relating to **HIV** infection status or treatment information	I **DO NOT**: _____ (initial here)
I DO authorize the disclosure of information relating to **ALCOHOL** or **DRUG ABUSE** diagnosis or treatment.	I **DO NOT**: _____ (initial here)
I DO authorize the disclosure of information relating to **MENTAL HEALTH** diagnosis or treatment.	I **DO NOT**: _____ (initial here)

***Exclude* the following information:** _____

I understand that:

- I can refuse to disclose some or all the health care information in my records, but that refusal may result in the inability of my case manager to coordinate certain services for me. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written request to Frannie Peabody Center except where information has already been acted upon a request for the release of information.
- I can cross out any provision on this form with which I disagree
- I understand that I am entitled to a copy of this authorization, upon request. But, I do not need to review any information before it is shared.

This permission is effective for one (1) year from the date of signing, unless otherwise noted here:

Optional Expiration Date (*Note expiration date if less than 1 year*): _____

I choose to share the information listed above with this entity. I understand the information will be used only for the reason(s) listed. This information will not be shared with anyone else without my permission, unless required by law.

Client Signature (*if 18 yrs or older*)	Date	Witness Signature	Date

Signature of Legally Authorized Representative (*if under 18 yrs old*)	Date	Printed name of Authorized Representative	Relationship to Client