HHSA Mental Health Division
2751 Napa Valley Corporate Drive
Napa, CA 94558
707-259-8151

Continuity of Care Request Form

Date: ______________________ Case #: _____________________

Beneficiary Information:

Last Name: _________________________ First Name: ________________ Middle Initial: _______

Date of Birth: ____________________________

Medi-Cal I.D.: ____________________________

Address: ________________________________City: ______________ State: ______ Zip: __________

Preferred Phone: ___________________________ ☐ Home ☐ Cell ☐ Work

Secondary Phone: ___________________________ ☐ Home ☐ Cell ☐ Work

Email: _____________________________________ May we contact you via email? ☐ Yes ☐ No

Reason for Request:

☐ Beneficiary has transitioned to the Napa County MHP from another county MHP due to a change in beneficiary county of residence;

☐ Beneficiary has transitioned from Medi-Cal Fee for Service to the Napa County MHP;

☐ Beneficiary has transitioned from a Managed Care Plan to the Napa County MHP;

☐ Pre-existing provider has voluntarily terminated employment or the contract with the Napa County Mental Health Plan (MHP);

☐ Pre-existing provider's employment or contract has been terminated for a reason other than quality of care or eligibility of provider to participate in Medi-Cal.

Pre-existing Provider Information:

Last Name: _________________________ First Name: ________________ Credential: ___________

Specialist/Type of Care: ____________________________ License No: ________________________

Last Date of Service with Provider: ___________________

Address: ________________________________City: ______________ State: ______ Zip: __________

Phone: _________________________________ Email: _________________________________

In order for Napa County Mental Health Plan to make an informed decision concerning your request for Continuity of Care, beneficiary must sign the attached *Authorization to Release Information* so that we may obtain the necessary information to validate the pre-existing provider. Beneficiary will be notified of the plan's decision in writing.

AUTHORIZATION TO RELEASE INFORMATION

Completion of this document authorizes the use and disclosure of your confidential health, financial, and personal information consistent with State and Federal law pertaining to the privacy of such information. Coordinating care, treatment and services will promote physical and mental health, safety, recovery and overall well-being that leads to a higher standard of care. **Review and complete all sections below for a valid authorization.**

1. Client Information:

First Name: ___________________________ Last Name: ___________________________

Date of Birth:_______________________Phone #: __________________________________

Address: ____

USE AND DISCLOSURE

2. Purpose of Authorization (check all that apply):

- ☐ Evaluation
- ☐ Treatment Planning
- ☐ Coordination of Care or Services
- ☐ Legal
- ☐ Financial
- ☐ At the request of the individual
- ☐ Other (specify):___________________

3. Description of Information To Be Disclosed or Exchanged– may be written or verbal (check all that apply):

- ☐ Complete Record
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ Assessments
- ☐ Social History
- ☐ Progress Notes
- ☐ Psychological or Vocational Testing
- ☐ Laboratory Results
- ☐ Discharge Summary or Aftercare Plan
- ☐ Probation or Correctional Proceedings
- ☐ Benefit or Eligibility Details
- ☐ Billing or Financial Records
- ☐ Verification of Services
- ☐ Other (specify) __________________

Date Range of Records to be Disclosed (if applicable):______________to ______________

To limit any information marked above, specify here: _______________________________

4. This Information Requires Special Protection

Initial to allow use and disclosure (if applicable):

Mental Health Records	*Initial Here*	Substance Use Disorder Records	*Initial Here*	HIV/AIDS Test Results	*Initial Here*	Genetic Testing	*Initial Here*	Sickle Cell Anemia	*Initial Here*

5. Recipients

(a) Initial two or more to facilitate the exchange of information between Programs (if applicable):

Initial Here	Napa County HHSA - Alcohol and Drug Services	*Initial Here*	Napa County HHSA - Public Health
Initial Here	Napa County HHSA - Child Welfare Services	*Initial Here*	Napa County HHSA - Self-Sufficiency Services
Initial Here	Napa County HHSA - Comprehensive Services for Older Adults	*Initial Here*	Other (specify): _______________
Initial Here	Napa County Housing and Homeless Services Division	*Initial Here*	Other (specify): _______________
Initial Here	Napa County HHSA - Mental Health	*Initial Here*	Other (specify): _______________
Initial Here	Napa County Probation	*Initial Here*	Other (specify): _______________

OR

(b) Specific person or organization to which disclosure is to be made (if applicable):

Name:	☐ **One-way**	Name:
Address:	→	Address:
City:	☐ **Two-way**	City:
State: Zip Code:	↔	State: Zip Code:
Phone: Fax:		Phone: Fax:

6. Expiration

Enter the **date** this authorization will expire: _______________

Napa County HHSA is an Equal Opportunity Provider

NOTICE OF YOUR RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability too obtain treatment, payment, or eligibility for benefits.
  Program name (optional): ________________
- I may revoke or cancel this authorization at any time. My revocation will be effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid. My revocation may be verbal or in writing, signed by me or my personal representative.
- I have a right to receive a copy of this authorization.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient, and unless prohibited by State or Federal laws, may no longer be protected.
- I may inspect or obtain a copy of the health information to which this authorization applies.
- I may request and receive clarification of any concerns or questions I may have regarding this authorization.

SIGNATURE

7. Required Signatures

Client or Personal Representative:________________________Date: _______________

Personal Representative[1] printed name: ____

☐ If checked, this authorization is not to exceed 12 months.

Internal Use Only

Program Contact printed name:____________________Phone number: __________________

[1] Personal Representative is the person who has legal authority to make decisions on behalf of the client.