Public Health
Prevent. Promote. Protect.
Somerset County Health Department

Somerset County Health Department

8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 ● Fax 410.651.5680 ● TDD 1-800-735-2258

Health Officer: Danielle Weber, MS, RN

Referral for State Care Coordination Services

(Must be a Somerset County resident (mandatory for state/county funding), or otherwise specified as "High Risk" category.)
(Please notify a MINIMUM of 5 days (when possible) prior to discharge if requesting housing assistance.)

Client Information

Name: _____ Beacon M#: _____

DOB: _____ SS#: _____

Race: _____ Hispanic Origin: Y / N Gender: _____

Client Main Phone: _____ Alternate Phone: _____

Address at time of admission: _____

_____

Emergency Contact: _____
Name Relationship Phone Number

The above named client is being referred for State Care Coordination services, and is requesting assistance with the following:

_____

_____

Recommended Level of Care Upon Discharge: _____

Diagnostic ICD-10 Code: _____ Expected Discharge Date: _____

Referring Agency: _____
Name of Agency Name of Person Referring

Client Signature: _____ Date: _____

For questions, call the Somerset County State Care Coordinator at 443-880-0299.
Fax completed referral and release forms to: 410-621-5426.

Beacon Health Data

Social Elements Impacting Diagnosis

	None		Health Care Access		Housing Problems (Not Homelessness)		Social Environment
	Educational Problems		Legal System / Crime		Occupational Problems		Homelessness
	Financial Problems		Problems with Primary Support Group		Other Psychosocial / Environmental		Unknown

Additional Reporting Data

Marital Status		Number of Dependent Children		Living Situation		Employment Status	
Source of Referral		Primary Source of Income		Type of Insurance		Mental Health Problems	
Pregnant		Tuberculosis Diagnosis		Tobacco Use 30 Days Prior to Admission		Highest Level of School Completed	
Is the consumer a Veteran?		# of arrests within past 30 days		# of arrests in the last 12 months		Self Help Group Attendance in last 30 days	

Substance Use History

Primary Substance

Substance		Total Years of Use		Usual Route of Administration		Length of Current Use	
Amount of Use		Frequency of Use		Age of First Substance Use		Date of Last Use	

Secondary Substance

Substance		Total Years of Use		Usual Route of Administration		Length of Current Use	
Amount of Use		Frequency of Use		Age of First Substance Use		Date of Last Use	

Tertiary Substance

Substance		Total Years of Use		Usual Route of Administration		Length of Current Use	
Amount of Use		Frequency of Use		Age of First Substance Use		Date of Last Use	

Public Health
Prevent. Promote. Protect.
Somerset County
Health Department

Somerset County Health Department

8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 ● Fax 410.651.5680 ● TDD 1-800-735-2258

Health Officer: Danielle Weber, MS, RN

Authorization for the Release of Confidential Information

Client Name: _____ DOB: _____ Patient ID# _____

Street Address: _____ Phone Number: _____

City, State, Zip: _____

I hereby authorize the Somerset County Health Department to: X Obtain X Release information to / from:

_____

The following information from my records (specify extent or nature of the information to be obtained or released):

_____

_____

The purpose of this authorized disclosure: _____

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 and 164. These regulations prohibit you from making further disclosure of it without the specific written consent to whom it pertains or as otherwise specified by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Conditions for Exchange of Authorized Information
Expiration: This authorization will expire one year from the date signed unless specified below by date or event less than one year:

Date: _____/_____/_____ Event or Condition: _____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice, but not retroactive to release of information already made in good faith. USE SPACE BELOW ONLY IF CLIENT WITHDRAWS CONSENT.

Date Authorization Revoked by Client: _____/_____/_____ Signature of Client: _____

REDISCLOSURE: Any individual or agency receiving Somerset County Health Department client information is prohibited from making further disclosure of the medical record. This is prohibited as provided by the Annotated Code of Maryland 4-303(b)(5)(ii).

PHOTOSTAT/FACSIMILE: A photostat or facsimile of this authorization is considered as effective and valid as the original.

Date: _____ Signature of Client: _____

Date: _____ Signature of Parent or Guardian: _____

Date: _____ Witness to Signature: _____