**A logo of a house with people and a heart

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**Welcome House NKY Payee Referral Form**

**IMPORTANT: We need the following Documents before we can continue the Payee Application Process, please attach to the referral.**

* **ID**
* **Social Security Card**
* **Birth Certificate**
* **787 Physicians Form**

|  |
| --- |
| Name and Phone Number: |
|  |
| Date of birth: |
|  |
| Social Security Number: |
|  |
| Mother’s Maiden Name: |
|  |
| Place of Birth (city and state) : |
| Gender: |
|  |
|  |
| Race and Ethnicity: |
|  |
|  |
| Are you an Employee or a board member of this agency? |
|  |
| Are you related to an employee or a board member of this agency? |
|  |
| Mental Health Diagnosis? Or any other Disability |
| Established Medical Home? |
|  |
| Homeless: No Yes Where did you sleep last night? |
|  |
| Income: SSI SSD VA or OTHER INCOME |
|  |
| Address: |
|  |
| Landlord Information: |
|  |
| How long at Address: |
|  |
| Rent Amount: |
|  |
| Other Bills: |
|  |
| **Family Contact information and Emergency Contact Information** |
| Name: |
| Phone number: |
| Address: |
| Notes: |
| **Referring Agency Information** |
| Name of Case worker: |
| Phone number: |
| Notes: |
| **Doctor Information:** |
| Name of doctor: |
| Address and phone number: |
| Mental Healthcare provider: |
| Medicaid: Yes /No Medicare: Yes/No |
| Insurance Name: Member Id: |
|  |
| Do you have a legal guardian or Power of Attorney: |
| Name: Contact Information: |
| Do you have a funeral trust, stable Account, burial plot, and or any other Assets? |
|  |
| Do you currently have a payee: Yes No |
| Name or Agency: Contact Information: |
| Why are you wanting to switch from your current payee? |
| Are you required to have a payee: Yes No |
| Please Explain Current Situation: |
|  |
|  |
|  |

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**General Authorization for Release of Confidential Information**

Client Name: \_ Date of Birth: SS#

The purpose of this form is to allow me to choose how my services are coordinated. I understand that it is my decision to give permission to Welcome House to talk to others on my behalf. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf

**By initialing on the line next to the agency/provider, I am allowing these providers to communicate and exchange information needed to coordinate and continue my service plan, treatment, and services. If I do not initial, I do not want the information exchanged with that provider/agency.**

|  |  |  |
| --- | --- | --- |
| \_ Brighton Center | \_ Gateway Com & Tech. College | \_ Recovery Network/MHA |
| \_ Cabinet for Health & Family Services | \_ Greater Cincinnati Behavioral | \_ School: |
| \_ Catholic Charities | \_ Health Point | \_ Section 8: |
| \_ Center for Ind. Living Options | \_ Housing Authority of Covington | \_ St. Elizabeth Health Care |
| \_ Duke Energy | \_ Landlord: | \_ St. Elizabeth Physicians |
| \_ Easter State Hospital | \_ Life Learning Center | \_ Social Security Administration |
| \_ Emergency Shelter of NKY | \_ Mental Health Court | \_ SUN Behavioral Health |
| \_ Employer: \_ | \_ NKY Career Center | \_ Transitions, Inc. |
| \_ Fairhaven Shelter | \_ North Key Community Care | \_ Veterans Administration |
| \_ Family/Friend: \_ | \_ Office of Vocational Rehabilitation | \_ Women's Crisis Center |
| \_ Family Promise | \_ Probation/Parole | \_ Other: \_ |

I understand I may revoke the authorization at any time, by written, dated communication. I can also specify which of the above documents I may or may not want obtained or released.

I understand that services are NOT contingent upon or influenced by my decision to permit the information release.

I understand that the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse Patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by regulation.

I understand that Welcome House participates in VESTA, a community software system. I understand the data about myself and others in my household who receive services are maintained in VESTA by Welcome House. However, this information will not be shared with external agencies. I understand I have the right to see my electronic record, ask for changes, and to have a copy of my record printed from VESTA upon written request.

**Date, Event or Condition when the Consent Expires: .** *In the event no date/event or condition is specified, this consent expires* ***one year*** *from the date of signing.*

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Client Signature Date Staff Signature Date