HFS
Illinois Department of
Healthcare and Family Services

# N.B. Interim Relief Application and Consent Form Instructions

Parents or legal guardians of youth who may be N.B. Class Members requiring Psychiatric Residential Treatment Facility (PRTF) services on an emergent basis may request Interim Relief Services by submitting a completed Application and Consent Form with a physician's letter of medical necessity to the HFS Bureau of Behavioral Health.

**Step 1:** Work with the youth's behavioral health provider to obtain a letter of medical necessity for Psychiatric Residential Treatment Facility (PRTF) services for the youth. The letter of medical necessity must be from a physician.

**Step 2:** Complete the **N.B. Interim Relief Services Application and Consent Form**.

**Section 1**: Complete the general information requested including the youth's recipient identification number (RIN).

**Section 2:** Read this box to understand the authorization of release of information.

**Section 3:** Review the type(s) of information you authorize to be released for the purpose of assessing individual and family service needs and to coordinate services. Write in any additional type(s) of information to be released (as appropriate) and cross out any type(s) of information that you do not authorize to be released.

**Section 4:** Review the persons or entities you authorize to receive, share, and use the youth's information that is identified in the section above. Write in any additional persons or entities to be authorized (as appropriate) and cross out any persons or entities that you do not authorize to receive, share or use the information.

**Section 5:** Read and confirm that you consent to Interim Relief Services and understand the expectations for participation.

**Section 6:** Sign and date to authorize release of information and apply for Interim Relief Services. This section must be signed and dated by the parent or legal guardian if the youth is under age 18, as well as the youth if the youth is age 12 or over. This section must also be signed and dated by a witness that is at least 18 years of age and is not signing the form as the youth or the youth's parent or legal guardian. Next, check the box to indicate if the authorization shall expire after six (6) months or 12 months. If the box is left unchecked, the authorization will expire 12 months after date of signature. Lastly, in this section you may add any additional information you wish to provide to the Department.

**Step 3:** Submit your completed application and consent form and letter of medical necessity electronically or by mail or fax.

**Mail applications to:**

Healthcare and Family Services
Bureau of Behavioral Health
Attn: Interim Relief Services
201 South Grand Avenue East, 3rd floor
Springfield, IL 62763

**Fax applications to:**
217-524-1221

**Submit applications electronically to the following email address:** HFS.BBH-InterimRelief@illinois.gov.
Applicants are strongly recommended to send any electronic submissions by encrypted email and any files or confidential information password protected.

**Notification:** HFS will review the application to make sure it is complete and verify whether the youth is a Class Member eligible to receive services through the N.B. Interim Relief process.

**If the youth is determined to be a Class Member eligible for N.B. Interim Relief Services:** The Department will provide written notification of this determination to the parent or legal guardian, or youth as appropriate. HFS has partnered with the University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC) to provide N.B. Interim Relief participants with care coordination and assistance in arranging appropriate services. The DSCC care coordinator will contact the parent or legal guardian, or youth as appropriate, to initiate the care coordination process and discuss options for locating appropriate services and providers to meet the youth's needs.

**If the youth is determined *not* to be a Class Member eligible to receive N.B Interim Relief Services**: The Department will provide written notification of this determination to the parent or legal guardian, or youth as appropriate, and to N.B. Class Counsel.

**If you have additional questions, please call 217-557-1000.**

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Tracking Number:

# N.B. Interim Relief Application and Consent Form

Please submit the application along with all required documentation, to HFS Bureau of Behavioral Health via mail, fax or electronically as provided in the application instructions.

## 1. GENERAL INFORMATION

| Youth's Name (Last name, First name): | Date of Birth: | Age: | RIN: |
|---|---|---|---|
| **Is the youth their own guardian?** ☐ Yes ☐ No *(If yes, skip the parent/guardian/caregiver section)* | **Does the youth live at home with Parent/Guardian?** ☐ **Yes** ☐ **No** *(If yes, skip the Placement section)* | **Youth's Current Residence or Location (if different from parent/guardian/caregiver):** | |

| Youth's City: | State: | Zip Code: | Youth's Contact Phone #: |
|---|---|---|---|

| Name of Youth's Parent/Guardian/Caregiver: | Parent/Guardian/Caregiver Phone #: | Parent/Guardian/Caregiver Email: ☐ N/A | |
|---|---|---|---|
| Parent/Guardian/Caregiver Address: | City: | State: | Zip Code: |

## 2. AUTHORIZATION FOR RELEASE OF INFORMATION

I recognize that sharing the information and records listed below is necessary to plan for and provide services for the youth. I hereby authorize the person(s) and entities listed below to release, receive, and use the information and records stated below for the purpose of assessing individual and family service needs and coordinating services. I understand that I may revoke this authorization; however, the revocation must be in writing. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person or entity otherwise authorized to disclose records and communications. I understand that I have the right to inspect and copy the information shared. I understand information about my case is confidential and protected by state and federal law. Refusal to sign this form will result in the following consequences: the youth and the youth's family will not be able to participate in N.B. Interim Relief Services.

## 3. THE FOLLOWING TYPES OF INFORMATION AND RECORDS WILL BE SHARED (Cross out any that are not authorized):

- Medical Records and Information
- Legal/Court Records and Information
- Drug and Alcohol Treatment Records and Information
- Records from other sources (Specify)_____
- Health information regarding HIV/AIDS
- Psychotherapy Notes
- Mental Health Assessment and Treatment Records and Information
- Psychiatric and Psychological Treatment Records and Information
- Developmental Disability and Related Services Information
- Educational Reports and Information
- Other (specify) _____
- Other (specify) _____

## 4. THE INFORMATION WILL BE SHARED WITH AND BETWEEN THE FOLLOWING INDIVIDUALS AND ENTITIES (Cross out any that are not authorized):

▸ HFS ▸ DSCC ▶ Physicians ▶ Psychiatrist ▶ Hospital ▶ Psychologist ▶ Schools ▶ Psychiatric Residential Treatment Facility or Residential Treatment Provider ▶ Therapist/Therapy Provider ▶ Psychologist ▶ Substance Use/Abuse Treatment Provider ▶ Illinois Department of Children and Family Services (if applicable) ▶ Illinois Department of Human Services (if applicable) ▶ Illinois State Board of Education / Local school district (if applicable) ▶ Court ▶ Care Coordination and Support Organization ▶ Mobile Crisis Response / Screening, Assessment and Support Services provider ▶ Managed Care Organization (if applicable) ▶ Other (Specify)_____ ▶ Other (Specify)_____

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## 5. Consent to Interim Relief Services

By signing this form, I hereby give consent for the above-named youth to participate in N.B. Interim Relief services, including care coordination by DSCC and HFS (or delegate).

I understand that HFS (or delegate) and DSCC make good faith efforts to connect each youth and family with providers of services that are appropriate to the individual's needs. The decision to utilize any provider's services is my decision. I agree to inform the provider of all pertinent facts about the youth's needs and disabilities as necessary to provide appropriate care and services for the youth.

I agree that the youth and I will participate in the coordination of services offered by HFS (or delegate) and DSCC. I understand I have the right to terminate services or withdraw consent for the youth to receive services at any time. I agree that HFS (or delegate) and the DSCC care coordinator may contact the youth and me by email, telephone, or text message, and that HFS and DSCC are not responsible for any charges incurred by me for any such communications.

I attest that I have provided the above information, either for myself or for the youth, and that this information is true, accurate, and complete to the best of my knowledge.

## 6. SIGNATURE

**Signature of client/youth** _____ **Date:** _____
**(Age 12 years and over)**

**Signature of Parent/Guardian** _____ **Date:** _____

**Signature of Witness** _____ **Date:** _____

**Unless I revoke this authorization earlier, it will expire in: ☐ 6 months ☐ 12 months or if no box is checked, it will automatically expire 12 months after the date signed by the youth and parent/guardian.**

**Notes:**

**HFS OFFICE USE ONLY**

Date Received:_____ Date Reviewed:_____ Reviewer Signature: _____

Approved for placement? ☐ Yes ☐ No Admission Date:_____ **Facility:**_____

**Dx:** _____