ILLINOIS DEPARTMENT OF Healthcare and Family Services

N.B. Interim Relief Application and Consent Form Instructions

Parents/guardians of youth who may be potential Class Members requiring Psychiatric Residential Treatment Facility (PRTF) services on an emergent basis may request Interim Relief Services by submitting a completed Interim Relief 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. The provider letter must be from a physician.

Step 2: Complete the **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 that you are authorizing a release of information in the next 2 sections.
- **Section 3:** Select the type(s) of information you authorize for release for the purpose of assessing individual and family service needs and to coordinate services.
- **Section 4:** Select the type(s) of persons or agencies you authorize to access the youth's information that is identified in the section above for the purpose of assessing individual and family service needs and to coordinate services.
- **Section 5:** Sign and date for authorization to release the records and information selected in sections 3 and 4.
- **Section 6:** Read and confirm that you understand the expectations for coordination of services by checking both of the boxes.
- **Section 7:** Sign and date authorization to begin coordination of Interim Relief Services. Next you may check the length of time the consent will last. Lastly, you have space to add any notations you feel are important the Department to be made aware of.

Step 3: Submit your completed application and letter of medical necessity by mail, fax or secure file transfer electronically.

Mail applications to:

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

Fax applications to:
217-524-1221

Submit applications electronically by secure file transfer email:

- Click this link: https://filet.illinois.gov/filet/pimupload.asp
- Follow that webpage's instructions to send the file to the following email address:
- HFS.BBH-InterimRelief@illinois.gov (Step 1)
- Include your email address (Step 2)
- Select the application file to send (Step 3)
- Include "IR Application" in the File Transfer Email Subject Line

Notification: HFS' Interim Relief Manager will review the application to make sure it is complete and verify whether or not the youth is a Class Member eligible to receive services through the Interim Relief process.

If the youth is determined to be a Class Member eligible for Interim Relief Services: The Department will provide written notification of this determination to the parent/guardian, or youth as appropriate; and the Interim Relief Manager will contact the family to discuss the most applicable services and providers to meet the youth's needs.

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

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

ILLINOIS DEPARTMENT OF Healthcare and Family Services

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 his/her 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 Child'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 Team members may need to share my information in order to plan for and deliver services/treatment to the youth. I hereby authorize the person (s) and agency/agencies listed below to release/exchange the information and reports designated below for the purpose of assessing individual and family service needs and coordinating services.

3. TYPE OF INFORMATION

- ☐ Medical Records
- ☐ Legal/Court Records
- ☐ Drug/Alcohol Treatment
- ☐ Records from other sources (Specify)_______________
- ☐ Health information regarding HIV/AIDS
- ☐ Other (specify)__________________________
- ☐ Mental Health Assessment and Treatment Plans
- ☐ Psychiatric Treatment/Reports
- ☐ Psychological Records/Reports
- ☐ Educational Reports
- ☐ Other Medical concerns(specify) _________________________
- ☐ Psychotherapy Notes

4. Authorized persons and agencies, if applicable

☐ HFS/UIUC ☐ Parent/Caregiver ☐ Psychiatrist ☐ Hospital ☐ Court ☐ Child Welfare Agency (if applicable) ☐ Psychologist ☐ Schools ☐ Family Advocates ☐ Psychiatric Residential Treatment Facility ☐ Therapist/Therapy Agency ☐ Psychologist ☐ Other (Specify)_______________________

5. Signature

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 otherwise authorized to disclose records and communications. I understand information about my case is confidential and protected by state and federal law; and,

I hereby authorize HFS (or delegate) to release information as required to assess individual and family service needs and to coordinate services; and,

I, ___________________________________, hereby 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. Refusal to sign this form will result in the following consequences: may limit my ability to fully participate in Interim Relief Services.

Signature: ____ **Date:** ___________________________

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6. Consent to Interim Relief Services

By signing this form, I hereby give consent for the above named youth to receive coordination of services from HFS (or delegate). I understand all communications may be confidential, in which case they may be disclosed and released only as set forth in a written authorization or as otherwise authorized by law. Exceptions to this confidentiality include, but are not limited to:

1. Where there is suspicion of child/adult abuse and/or neglect;
2. Where there is a belief that the Client is in danger to him/herself or others;
3. In a medical emergency where information is necessary to protect health and safety;
4. In response to a valid court order or subpoena

I further understand the following:

☐ The Role of the Interim Relief Manager is to help the youth in achieving goals and objectives, including planning for when treatment goals have been met;
☐ The Interim Relief Manager will keep me informed of program changes or requirements.

I understand that HFS (or delegate) makes good faith efforts to connect each youth and his/her family with providers of services who have skills and training in caring for children in a variety of areas. 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). I understand I have the right to terminate services or withdraw consent for the youth to receive services at any time. I agree that the Interim Relief Coordinator may contact the youth and me by email, telephone, or text message, and that HFS is not responsible for any charges incurred by me for any such communications.

7. SIGNATURE

Signature of client/youth ____________________________________ **Date:** ______________
(over 12 years of age)

Signature of Parent/Guardian ____________________________ **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 client/ guardian.

Notes:

HFS OFFICE USE ONLY

Date Received:________________ Date Reviewed:______________________ Reviewer Signature: ___________________

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

Dx: _________________

a. Attachments: _________