ADVANTAGE
WHERE HEALTH MEETS HOPE

Welcome and thank you for your interest in Advantage Behavioral Health Systems: **System of Care Program.**

Enclosed you will find a **System of Care Referral Form** and **Release of Information (ROI).** Please email both completed forms to youthservices@advantagebhs.org

**What we do:** The System of Care program provides community based services and support to individuals who are ages 5-26 with or at risk for mental health challenges and their families. We work in a coordinated network to build meaningful partnerships with families and youth to address cultural and linguistic needs in order to help them function better in their home, school, community and throughout life. We focus on education, employment, social connectedness, accessing behavioral health services, resiliency and vocational/independence development.

**Who do we serve:** Services are primarily provided to residents in Clarke County. Advantage services ten counties which include: Madison, Elbert, Oglethorpe, Greene, Morgan, Oconee, Barrow, Jackson, Walton and Clarke. System of Care services may be provided to those living in the above counties on a case by case basis depending upon availability and resources. **We provide services for individuals ages 5-26.**

**Referrals:** Referrals can be made to Advantage Behavioral Health via email at: youthservices@advantagebhs.org

If the individual is currently an Advantage client, services may begin immediately. If the individual is not currently receiving services from Advantage they will need to complete an intake assessment. During this intake assessment the individual will be assessed by a clinician to review what symptoms or issues they are experiencing, medical history and other pertinent information which will help create a treatment plan. This intake assessment typically takes **about 1.5 hours** to complete. This can be completed at the closest outpatient clinic to them. When they arrive at the clinic they will inform them that they would like to complete an intake assessment to begin receiving services with Advantages System of Care Program (they can communicate other services they would like to receive through Advantage at this time as well). **Once the individual has completed the intake assessment, it is their responsibility to inform the System of Care Coordinator so that services may begin. SOC Coordinator: Rebecca Hiner can be reached at: rebecca.hiner@advantagebhs.org or (706) 424-8633.**

**Below are a list of outpatient clinic locations:**

**Greene County**
1040 Silver Road
Greensboro, GA 30642
Phone (855) 333-9544
**Hours**
Monday thru Friday, 8:30 a.m. to 5 p.m.

**Clarke County**
240 Mitchell Bridge Rd.
Athens, Ga. 30606
Phone: (855) 333-9544 or (706) 389-6767
**Hours**
Monday thru Thursday, 8am to 6pm & Friday 8am to 5pm

**Jackson County**
383 Stan Evans Drive
Jefferson, GA 30549
Phone (855) 333-9544
**Hours**
Monday thru Friday, 8:30 a.m. to 5 p.m.

**Walton County**
834 State Hwy 11 SW
Monroe, Ga. 30655
Phone: (855) 333-9544
**Hours**
Monday thru Friday, 8:30am to 5pm

**Barrow County**
98 Lanthier Street
Winder, Ga. 30680
Phone: (855) 333-9544
**Hours**
Monday thru Friday, 8:30am to 5pm

**Elbert County**
50 Chestnut Street
Elberton, Ga. 30635
Phone: (855) 333-9544
**Hours**
Monday thru Friday, 8:30am to 5pm

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# System of Care Referral Form

**Date of Referral:** _____

**Youth/Client Information:**

Name: _____ DOB: _____ SSN: _____ Gender: _____

Race: _____ Primary Language: _____ School: _____

Address: _____

**Guardian Information:**

Name: _____ Phone/Email: _____

Address: _____

Name: _____ Phone/Email: _____

Address: _____

**Insurance Information:**

Insurance Type: _____ Insurance Number: _____

**Referring Person Information:**

Name: _____ Phone/Email: _____

School/Office: _____ Position: _____

**Reason for referral/comments:**

_____

_____

_____

**Other agencies/services individual is receiving and interventions/supports in place:**

_____

_____

**Are they currently receiving services from Advantage Behavioral Health Systems?** ___ Yes ___ No

If yes, what? _____

**Does this person have an IEP, 504, or school psychological report?** ___Yes ____No

If yes, please enclose documentation for review if available.

**Does this person have Developmental or Intellectual Disabilities?** ___Yes ____No

If yes, please explain: _____

**Please email all completed referrals to youthservices@advantagebhs.org**

# ADVANTAGE Authorization for Release of Protected Health Information

*****Legal: ALL ENTRIES MUST BE COMPLETED IN ORDER FOR THIS AUTHORIZATION TO BE EFFECTIVE*****

This form shall NOT be altered, amended, or modified from its original form without express written consent from Advantage

Name of Client | Date of Birth | Last 4 Digits of Social Security Number

**I Hereby Authorize:** **Advantage Behavioral Health Systems 250 North Avenue, Athens, GA 30601**
**Phone: 706-389-6789 Medical Records Fax: 706-389-6775**

**TO:** ☐ ___Release information to ☐ ___Obtain information from ☐ ___Talk face to face with ☐ ___ Have phone contact with

**THE FOLLOWING:** _____
(Individual/Agency/Physician/Attorney/Other)

_____
(Street Address)

_____
(City, State, Zip Code) (*FAX number)

**For the Purpose of:** _____ Healthcare _____ Legal ☐Other: _____

**Disclose material from *Date(s) of Treatment**:** _____

☐ _____ Diagnosis ☐ _____ Initial Evaluation _____ Individual Service Plan ☐_____ Progress Notes

_____ Medication(s) _____ Discharge Summary Other: _____

**I understand that:**

1. I am not required to sign this authorization in order to receive treatment, and it will not affect my payment status.
2. Disclosure of health information is voluntary.
3. Any disclosure of information carries with it the potential for an unauthorized re-disclosure.
4. Per federal law (42 CFR 2.32), alcohol and drug abuse records that I authorize to be disclosed per this document may not be further re-disclosed without my written consent.
5. I may inspect or obtain a copy of the information described on this form if I request it, unless otherwise prohibited by law.
6. I may refuse to sign this authorization.
7. I get a copy of this form after I sign it.
8. I may revoke this authorization in writing at any time and present my written revocation to Advantage.
9. The revocation will not apply to information that has already been released in response to this authorization.
10. If I have any questions about the disclosure of my protected health information, I can contact the ABH Privacy Officer.

**I understand** that this form authorizes the release of medical records **including psychiatric, psychological, or other mental health records.**
**I understand that I must enter *my initials below* to authorize the release of *any of the following*:**

_____ I authorize the release of ***drug or alcohol diagnosis and/or treatment*** information.
(Initials)

_____ I authorize release of information concerning ***treatment and testing for HIV/AIDS*** or other statutorily-protected disease.
(Initials)

_____ I authorize the release of my protected health information ***to the Court***.
(Initials)

_____ I authorize Advantage Behavioral Health ***clinician(s) to testify*** about my treatment in legal proceedings/***Court***.
(Initials)

_____ I authorize the release of ***Individual Therapy*** notes from my treatment record.
(Initials)

**I have read the above and authorize the disclosure of the protected health information as stated. If I fail to specify an expiration date, this authorization will expire one (1) year from the date of signature.** Alternate Expiration Date: _____

Signature of Client or Legal Representative | Relationship to client | Date of Signature

Signature of Witness | Date of Signature

**For REVOCATION ONLY-**
**This Authorization REVOKED on** (sign and date): _____ _____
(Signature of Client/Legal Representative) Date of Signature