

As a student enrolled in Maine's Pathways to Partnerships, you and your family have access to individualized **Benefits Education** and **Benefits Counseling** to learn how work is possible when getting government benefits.

- **Benefits Education:** Are you looking for information about government benefits such as Social Security disability benefits, MaineCare, and ABLE accounts? This service is for P2P students who are not currently receiving government benefits or who have questions about benefits changing when they turn 18. **Note:** we cannot help you apply for Social Security disability benefits.
- **Benefits Counseling:** Do you want to learn how working impacts your child or family's current benefits? This service is for P2P students receiving *any government benefit* (e.g. Social Security, SNAP, MaineCare, housing) **AND** any adult family member receiving Social Security disability benefits, State Supplemental Security Income, or a MaineCare waiver.

To request services, submit this form and Release of Information to us by email, fax, or mail. We will contact you after receiving your form!

Email to: bcs@mainehealth.org
Fax to: (207) 662-6789
Mail to: MaineHealth Vocational Services, Attn: BCS, 22 Bramhall Street, Portland ME 04102
Call us: 1-888-208-8700

1. **Student Name:** _____ **Student DOB:** _____

2. **School:** _____

3. **Parent/Guardian Name(s):** _____

4. **Parent/Guardian Phone Number:** _____

5. **Parent/Guardian Email:** _____

6. **Which services are you interested in?**

- Benefits Education Benefits Counseling

7. **What benefits does your household currently receive? Check all that apply.**

- Social Security benefits Medicare
 SNAP (Food Stamps) MaineCare
 Housing (Section 8, Public Housing, BRAP) Other: _____

8. **Is there anything else you would like us to know?**



Pathways to Partnerships

Services to Children and Youth (ages 10–24)

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION
 (PHI) AND/OR PERSONALLY IDENTIFIABLE INFORMATION (PII)

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Please Print: NOTE: Information must be fully completed for this form to be considered valid

Name:	Date of Birth:	Email:
Address:		Phone:
City:	State:	Zip Code:

 I hereby authorize MaineHealth Vocational Services, 22 Bramhall Street, Portland, ME 04102 207-662-2088 and its authorized employee or agent to:

1	<input type="checkbox"/> Release case records to	<input type="checkbox"/> Receive case records from	<input type="checkbox"/> Verbal or written communication with
Name/Facility:		Date(s) of Service:	
Street:			
City:		State:	Zip:
Phone:		Fax:	
2	<input type="checkbox"/> Release case records to	<input type="checkbox"/> Receive case records from	<input type="checkbox"/> Verbal or written communication with
Name/Facility:		Date(s) of Service:	
Street:			
City:		State:	Zip:
Phone:		Fax:	
3	<input type="checkbox"/> Release case records to	<input type="checkbox"/> Receive case records from	<input type="checkbox"/> Verbal or written communication with
Name/Facility:		Date(s) of Service:	
Street:			
City:		State:	Zip:
Phone:		Fax:	
4	<input type="checkbox"/> Release case records to	<input type="checkbox"/> Receive case records from	<input type="checkbox"/> Verbal or written communication with
Name/Facility:		Date(s) of Service:	
Street:			
City:		State:	Zip:
Phone:		Fax:	

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION
(PHI) AND/OR PERSONALLY IDENTIFIABLE INFORMATION (PII)

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Purpose of release: Service Coordination Vocational and work incentives planning Other: _____**AUTHORIZATION TO RELEASE SENSITIVE INFORMATION:**I DO authorize the disclosure of any information relating to diagnosis and or treatment of **Mental Health** I DO NOT I want to review such mental health information prior to being sentI DO authorize disclosure of any information relating to **Alcohol, Substance, and/or Drug Use** I DO NOTI DO authorize disclosure of information which refers to **HIV Results, Infection Status and/or Treatment** I DO NOT

Specific information/data to be released, if any:

I understand that:

- the information to be released may be from my electronic record and/or paper records. I understand that the data from the electronic record is current as of the date printed. I understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and that the page numbers reflect the printed document, not actual pages in the electronic record
- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences
- I can revoke all or part of this authorization at any time during this time period by providing written notice to MaineHealth Vocational Services, except where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits or other insurance coverage or benefits
- if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information
- I am entitled to a copy of this authorization, upon request

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization, unless I notify MaineHealth Vocational Services in writing that no future disclosures should be made.

X

Signature of Individual Guardian Authorized Representative

Date_____
Printed Name