EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID (MASSHEALTH)

PERMISSION TO GET AND SHARE INFORMATION IN THE MASSHEALTH CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) SYSTEM

Name of MassHealth member (Member) _____

Name of behavioral-health assessor (Assessor) _____

Name of provider organization (Provider) _____

Provider address _____

_____(Member) is under the age of 21 and is receiving a behavioral health assessment.

What is the CANS?

Behavioral-health providers (providers) use a tool called the Child and Adolescent Needs and Strengths (CANS) to collect behavioral health clinical information about members under 21. For members who are in ongoing treatment, a provider will regularly update the CANS at least every 90 days.

The information collected using the CANS tool (CANS Information) helps providers to do a number of things, such as:

- decide what behavioral health services a member may need
- check over time that behavioral health services are helping the member

Why MassHealth Wants to Obtain and Share CANS Information?

MassHealth has a computer system that a provider can use to enter CANS Information each time a behavioral health assessment is done or updated. MassHealth wants to use the system to access CANS Information and share it with providers and MassHealth managed care entities (organizations that manage and pay for a member's care) so that such parties can work together to make sure that the behavioral health services offered to the member meet the member's needs. Sharing CANS Information through the system will also help better inform the member's providers of the member's medical history and reduce the overall amount of information that such providers must collect from the member, as further described below.

If you give your permission, the Provider noted above will enter any CANS Information that it collects about the Member into the MassHealth system. Through this system, MassHealth will be able to access such information and make it available to the Provider for future access. MassHealth will also use the system to give the Provider access to any CANS Information entered by the Member's other providers. This will allow the Provider to update the Member's CANS Information when needed, rather than redoing the whole CANS again. If you agree, MassHealth will also use the system to give the Member's other providers with permission access to the CANS Information entered by the Provider in the CANS system, so they will understand the Member's history and may not need to ask the Member to repeat as much information. Your permission will also allow

MassHealth to use the system to give a MassHealth managed-care entity in which the Member is enrolled access to CANS Information collected by the Provider.

Your Permission

By signing below, you give permission for the Provider listed above to:

- enter all of the CANS Information about the Member that it collects into the MassHealth system
- view and copy any CANS Information about the Member that other providers have entered into the MassHealth CANS system

By signing below, you also give permission for MassHealth to use the system to share CANS Information collected by the Provider with:

- the Provider noted on the first page of this form
- the MassHealth managed-care entity in which the Member is enrolled at the time that the CANS is entered into the MassHealth CANS system
- other providers for whom you have given permission

Things You Should Know

Neither MassHealth nor the Provider may condition treatment, payment, enrollment or eligibility for benefits on whether you sign this form or whether you decide to take back the permission in the future.

If you give your permission to the activities noted above, the Provider will enter CANS Information about the Member into the MassHealth system, and MassHealth will access such information and share it with the Provider, other providers for whom permission is given and the Member's managed-care entity. Your permission will also allow MassHealth to give the Provider access to CANS Information entered into the system by the Member's other providers. **Note that even if you do not provide your permission, MassHealth and the Provider may still use or disclose CANS Information about the Member as required or permitted by law.**

After CANS Information is shared through the MassHealth system, the organization that shared the information will no longer be able to control how it is used or disclosed. The privacy laws covering CANS Information may be different when MassHealth, providers, or managed care entities hold the information, but each such organization must follow the privacy laws that apply to it when using or disclosing the information.

You may put a permission end date on this form below. If you do not, the permission ends one year from when you sign this form.

You may cancel this permission at any time in writing. The cancellation will prevent the Provider and MassHealth from using the MassHealth system to share CANS Information that is collected after you cancel your permission. Information that has already been made available to MassHealth, managed care entities, the Provider or other authorized providers through the MassHealth system prior to receipt of your cancellation cannot be taken back.

The written cancellation must:

- say who the Member is
- give the Member's birth date
- say who you are
- say if you are the Member, the Member's custodial parent, or explain why you can act for the Member
- say that you are cancelling your permission to enter and share CANS Information online

You must give the written cancellation to the Provider at the address noted on the first page of this form. The Provider must then notify MassHealth by emailing a scanned copy of the written cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Your Signature

By signing this permission form, you are giving permission for the uses and disclosures of CANS Information about the Member as noted above. You are also saying: that you have read the whole form and signed it willingly; and that you have the right to get a signed copy of the form.

_____

Printed name of person signing permission

_____

Signature of person signing permission

_____

Date of signing (date permission starts)

_____

Date permission ends (If no date is written on this line, permission will end one year from the date of signing.)

Please check the line below saying why you can sign this permission under law.

_____ I am the Member. I am 18 years old or older. If I am not 18 years old or older, I can give my permission for other reasons under law.

_____ I am the Member's custodial parent.

_____ I am able to act for the member to give permission to give out medical information. I have attached a legal document showing why I can do this.

Reminder to Provider: A signed copy of this form must be given to the Member or caregiver. If the Member or caregiver later cancels this consent, you must e-mail a scanned copy of the cancellation letter to: CANS-CBHI@MassMail.State.MA.US