Client Information & FAQs About ICANS

What is ICANS?

ICANS is a secure, electronic, internet-based, system used to administer and manage CANS assessments, WInS Wraparound Plans of Care, WInS Wraparound Crisis & Safety Plans, and WInS Wraparound Transition Plans in Idaho.

Why do I want my child's information available in ICANS?

The Child and Adolescent Needs and Strengths (CANS) is a tool for measuring your child and family's needs and strengths. The CANS is used in Idaho to help determine a child or youth's level of functional impairment and guide treatment planning decisions. In Idaho, the ICANS system uses the information from the CANS Assessment to help clinicians and other providers of children mental health services recommend the appropriate level of care.

To participate in or receive certain state-funded programs, such as the Youth Empowerment Services (YES Program), a child/youth will need to complete a CANS Assessment.

ICANS is the Idaho approved platform to administer and score the CANS, WInS Wraparound Plans of Care, WInS Wraparound Crisis & Safety Plans, and WInS Wraparound Transition Plans. By not allowing your child's information to be available in the ICANS system your child may not be able to access certain state-funded services or programs.

Permitting your child's information to be entered into the ICANS system allows it to be available to authorized providers and staff to make more informed, collaborative decisions regarding your child's mental health services and care.

Why do I need to complete and sign the informed consent?

By completing and signing the informed consent release form, you allow the agency listed to enter your child's information into the ICANS system.

Without the completed and signed informed consent release form, your provider cannot enter your child's information into the ICANS system.

Who may input my child's information into the ICANS system?

The agency that you have named at the top of the informed consent release form has permission to add your child's information to ICANS.

Who will have access to your child's information in ICANS?

Authorized users may have access to your child's information in ICANS.

An authorized user is an individual designated by a provider agency or Idaho Department of Health and Welfare Division of Behavioral Health needing to access ICANS for their job. Examples of potential authorized users may include, but are not limited to:

- Division of Behavioral Health Children's Mental Health staff.
- Division of Family and Community Services (FACS) staff, including Developmental Disabilities and Child Welfare if your child is involved in their programs.
- Medicaid and/or Optum staff who are responsible for the coordination, payment, and quality management of behavioral health services in Idaho.
- Independent Assessment providers, who are contracted by Medicaid, who will assess children for eligibility for some state-funded children's mental health services.
- Providers who are contracted by the Department of Health and Welfare to administer WInS Wraparound Plans of Care, WInS Wraparound Crisis & Safety Plans, and WInS Wraparound Transition Plans.

All ICANS users must also abide by the ICANS policies and procedures which include Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy and security standards. Use of the ICANS system for any other reason is strictly prohibited.

What information may be viewable by ICANS authorized users?

Limited information entered into the ICANS system is viewable to all authorized users.
Only the following information in the ICANS system **may be shared** with all authorized users:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)

*The Social Security Number (SSN) is collected for the purpose of identification of the participants, prevention of duplication of benefits and information. The SSN is a fundamental component for case management and care coordination activities.

The Department of Health and Welfare is authorized to collect and use social security numbers (SSN) to determine Medicaid eligibility, verify information, and prevent duplicative participation. Providing your SSN may minimize administrative delays associated with the requested service. The Department will not disclose an individual's SSN without the consent of the individual to anyone outside of the Department except as mandated by law. 31 CFR 1.32; 42 CFR §435.910.

The following information in the ICANS system is **not shared** with authorized users without a specific signed Release of Information:

- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes

How do I share my child's information between my child's treatment providers?

A specific completed and signed Release of Information must be completed *in addition* to the ICANS informed consent release form so that your child's provider can access records completed by another provider agency.

What information may be viewable by my child's treatment provider?

Your child's treatment provider can access any ICANS records for your child that have been entered by that specific provider and/or agency.

Please Note: A specific signed Release of Information must be completed *in addition* to the ICANS informed consent release form so that your child's provider can access records completed by another provider agency. The following information is available to your child's provider:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)
- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes
- Information entered into ICANS related to WInS Wraparound Plans of Care, WInS Wraparound Crisis & Safety Plans, and WInS Wraparound Transition Plans

Can I revoke the ICANS informed consent release form?

You may revoke the ICANS informed consent release form at any time. This will prevent any future use of ICANS but does not change any action that has already taken place using the informed consent release form.

After the informed consent release form has been revoked, the informed consent release form is no longer valid from that date forward. Copies or exact reproduction of the completed and signed informed consent release form will have the same force and effect as the original.

How is my child's privacy protected?

Information shared through ICANS is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; 45 C.F.R. Parts 160 & 164; and the Medicaid Act, 42 C.F.R. Part 431, Subpart F.

The ICANS system and participating providers use a combination of safeguards to protect your child's health information.

- Technical safeguards include encryption, password protections, and audit logs that track every participant's use of the system.
- Administrative safeguards include written policies that require limited access to information through ICANS. All participating providers must agree to follow these policies.
- The ICANS Security Safeguards can be found online at: http://icans.dhw.idaho.gov/ResourcesandUserGuide/tabid/4105/Default.aspx

All participating providers are also regulated by HIPAA, and other federal and state privacy laws. Providers must also have their own policies and other safeguards in place, including policies to train their staff and limit access to those who have a need to know.

Have questions not covered by this flyer or have concerns?

Please speak with your local Idaho Department of Health and Welfare Children's Mental Health office.

healthandwelfare.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

ICANS Informed Consent

I, _____ *(parent's name)*, am the parent or legal guardian of

_____ *(minor client's name)*.

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, WInS Wraparound Plan of Care, WInS Wraparound Crisis & Safety Plan, WInS Wraparound Transition Plan, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency Innovative Health Care Concepts (*name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 162 & 164; and Medicaid Regulations for safeguarding information, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any individual receiving alcohol or drug abuse treatment.

PURPOSE AND EFFECT.
I understand this authorization will allow my treatment team to plan and coordinate services I need and will allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time by submitting a Request to Restrict Access form to ICANSRestrictionRequests@dhw.idaho.gov. I acknowledge that revocation will prevent future disclosure of information in ICANS but will not impact any disclosures that have previously been made in reliance upon the executed Informed Consent Release form.

EXPIRATION.
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

If signing electronically please fill out these two columns first

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – *Required if Client is under 16 years of age, but only after signed by client.*	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**

Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™

Idaho Independent Assessment Services Program
8850 W. Emerald St. - Suite 164| Boise, ID 83704 | 208.258.7980 | Fax: 208.258.7985

PROTECTED HEALTH INFORMATION RELEASE ACCESS REQUEST FORM

I hereby authorize Liberty Healthcare Corporation Independent Assessment Program to **disclose AND/OR [circle one] receive** records for:

Applicant name:_____ DOB:_____
From/To: Innovative Health Care Concepts Phone: 208-523-6727
Address: 115 E. 16th. St. Idaho Falls, ID 83404

The following information: [Check all that apply]

X Comprehensive Diagnostic Assessment (CDA)	X CANS-100 Results	____Psychological Evaluation
____ Neuropsychological Evaluation	____Physician Note	____Hospitalization Records
X Notice of Determination	X ICANS Portal Authorization	
____ Other _____		

Conditions- I understand that Liberty Healthcare Corporation will not condition my assessment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have consequences including, but not limited to impacting the outcome of coordinated care.
Please Note- Medical records may contain sensitive information including, but not limited to: Alcohol, Drugs, Mental Health, HIV/AIDS, and Sexually Transmitted Diseases.

Purpose- The purpose of this disclosure of information is to improve comprehensive assessment and share information relevant to assessment and when appropriate, coordinate treatment services.

Revocation- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Liberty Healthcare Corporation Independent Assessment Program at 8850 W. Emerald Street, Suite 164, Boise, ID 83704. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

Form of Disclosure- Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration- Unless sooner revoked, this authorization expires in one (1) year on the following date: 1 year from today **, or as otherwise indicated:**_____**.**

_____
Printed Name and Signature of Applicant Date

_____
Printed Name and Signature of Parent or Legal Guardian Date

ALERT® Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name , First Name

Date of Birth: (mm/dd/yy) / /

Subscriber ID

Authorization #

Clinician Last Name , First Name

Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID

Clinician Phone -

State

MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

ALERT® Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name , First Name Child's Date of Birth: (mm/dd/yy) / /

Subscriber ID Authorization #

Clinician Last Name , First Name Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID Clinician Phone - State

MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

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Clinician: Please fax to (800) 985-6894

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