**Initial Program Evaluation Form**

**Name: Client ID:**

**Age:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**DOB:** Click or tap here to enter text.

**Last 4 SSN:** Click or tap here to enter text.

**Race & Ethnicity: Check all that apply:** [ ]  **Hispanic** [ ]  **Non-Hispanic**

[ ]  **Asian** [ ]  **Native Hawaiian** [ ]  **Other Pacific Islander**

[ ]  **Black/African American** [ ]  **American Indian/Alaska Native** [ ]  **White**

**Insurance:**

[ ]  **None/Uninsured** [ ]  **Duel Eligible (Medicare & Medicaid)**[ ]  **Medicaid/CHIP Only** [ ]  **Medicare Plus Supplemental**

[ ]  **Medicare Only** [ ]  **Other Third Party**

[ ]  **Unknown**

**Please describe the best way(s) to reach you. Please check and describe specifics. Please note, we will not leave personal messages regarding your services without your consent.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Method of Communication** | **Details** | **Do you prefer this method?** | **Consent to Contact with a request to reach our office?** | **Consent to leave detailed messages?** |
| Home Phone |  | [ ]  Yes [ ]  No  |  |  |
| Mobile Phone Call |  | [ ]  Yes [ ]  No  |  |  |
| Mobile Phone Text |  | [ ]  Yes [ ]  No  |  |  |
| Social Media |  | [ ]  Yes [ ]  No  |  |  |
| Address |  | [ ]  Yes [ ]  No  |  |  |
| Other - Specify |  | [ ]  Yes [ ]  No  |  |  |

\*Please note that Peer Recovery Specialists licensing standards do not allow staff to “friend” program participants. However, we may send you messages through our program account that is not connected to our personal pages.

If you stated yes to an address, please state the address(es) where we may reach you.

Click or tap here to enter text.

Staff Signature and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Initial Referral

**RHOP Target Population & OUD Verification Form**

|  |
| --- |
| **Client ID** |
| OUD is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period. | Yes | No |
| Opioids are often taken in larger amounts or over a longer period than was intended.  |[ ] [ ]
| There is a persistent desire or unsuccessful efforts to cut down or control opioid use.  |[ ] [ ]
| A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.  |[ ] [ ]
| Craving, or a strong desire or urge to use opioids. |[ ] [ ]
| Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home. |[ ] [ ]
| Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. |[ ] [ ]
| Important social, occupational, or recreational activities are given up or reduced because of opioid use.  |[ ] [ ]
| Recurrent opioid use in situations in which it is physically hazardous. |[ ] [ ]
| Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. |[ ] [ ]
| Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. A markedly diminished effect with continued use of the same amount of an opioid. Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.  |[ ] [ ]
| Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms. |[ ] [ ]

**Required certifications:** Each person signing below certifies to the following: (1) To the best of my knowledge, the program participant named above meets all requirements to receive assistance under RHOP. (2) To the best of my knowledge and ability, all of the information used in making this eligibility determination is true and complete.

Was SBIRT conducted? [ ]  Yes [ ]  No <http://sbirtapp.org/intro> SBIRT Score: Click or tap here to enter text.

Please print SBIRT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature Date Supervisor Signature Date

[ ]  I responded to an overdose and it was clear that the individual has OUD.

\*Initial Referral

**Community Services Block Grant Customer Intake Application**

|  |  |  |
| --- | --- | --- |
| **Client Number:** | **Agency:** | **Application Date:** |
|  |  |  |
| **Primary Applicant First Name** | **M.I.** | **Last Name** |
|  |  |  |
| **Social Security Number** | **Date of Birth** | **Gender** |
|  |  | 🞎 Female 🞎 Other🞎 Male |
| **Household Information:** |
| **Household Size:** | **Family Type** | **Building Type** |
|  | [ ]  Single Parent/Female[ ]  Single Parent/Male[ ]  Two-Parent Household[ ]  Single Person[ ]  Two Adults/No Children[ ]  Non-related Adults with children[ ]  Multigenerational Household[ ]  Other | [ ]  Mobile Home[ ]  Single Family [ ]  Multi-family low rise (3 stories or less)[ ]  Multi-family high rise (3 stories or more) |
| **Housing Status** |
| [ ]  Own[ ]  Rent[ ]  Other Permanent Housing[ ]  Homeless[ ]  Other |
| **Customer Address:** |
| Current Service Address: | Apartment/Lot/Unit Floor: |
|  |  |
| Current Mailing Address (if different from above): | Apartment/Lot/Unit Floor: |
|  |  |
| City: | State: | Zip Code: | County: |
|  |  |  |  |
| Phone Number: | Email Address: |
|  |  |
| Preferred method of contact? |
| **Primary Applicant Demographic Information:** |
| **Ethnicity** | **Race** | **Education** |
| [ ]  Hispanic, Latino or Spanish Origins[ ]  Not Hispanic, Latino or Spanish Origins | [ ]  American Indian/Alaskan Native[ ]  Asian[ ]  Black/African American[ ]  Native Hawaiian/Other Pacific Islander[ ]  Other[ ]  Unknown/Not-reported[ ]  White | [ ]  Grade 0-8[ ]  Grades 9-12/Non-Graduate[ ]  High School Grad/GED[ ]  12+ Some Post-Secondary [ ]  Education[ ]  2 or 4 Year College Graduate[ ]  Graduate or other post-secondary school |
| **Client Disabled?**  | **Military Status** | **Is Client a US Citizen?** |
| [ ]  Yes | [ ]  Veteran[ ]  Active Military  | [ ]  Yes |
| **Work Status** | **Health Insurance Type** | **Non-Cash Benefits** |
| [ ] Employed full-time[ ] Employed part-time[ ] Migrant Seasonal Farm Worker[ ]  Unemployed (6 months or less)[ ] Unemployed (more than 6 months)[ ] Unemployed (not in labor force)[ ]  Retired[ ]  Unknown/not reported[ ] Youth ages 14-24 who are neither working nor in school | [ ]  Medicaid[ ]  Medicare[ ]  Private/Employment Based[ ]  Self-Insured/Direct Pay[ ]  None[ ]  State Children’s Health Insurance Program[ ]  State Health Insurance for Adults | [ ]  Affordable Care Act Subsidy[ ]  Childcare Voucher[ ]  Housing Choice Voucher[ ]  HUD-VASH[ ]  Other[ ]  Permanent Supportive Housing[ ]  Public Housing[ ]  SNAP[ ]  WIC |
| **Additional Household Members:** |
| **First Name** | **M.I.** | **Last Name** |
|  |  |  |
| **Social Security Number** | **Date of Birth** | **Gender** |
|  |  | 🞎 Female 🞎 Other🞎 Male |
| **Ethnicity** | **Race** | **Education** |
| [ ]  Hispanic, Latino or Spanish Origins[ ]  Not Hispanic, Latino or Spanish Origins | [ ]  American Indian/Alaskan Native[ ]  Asian[ ]  Black/African American[ ]  Native Hawaiian/Other Pacific Islander[ ]  Other[ ]  Unknown/Not-reported[ ]  White | [ ]  Grade 0-8[ ]  Grades 9-12/Non-Graduate[ ]  High School Grad/GED[ ]  12+ Some Post-Secondary [ ]  Education[ ]  2 or 4 Year College Graduate[ ]  Graduate or other post-secondary school |
| **Client Disabled?**  | **Military Status** | **Is Client a US Citizen?** |
| [ ]  Yes | [ ]  Veteran[ ]  Active Military  | [ ]  Yes |
| **Work Status** | **Health Insurance Type** | **Non-Cash Benefits** |
| [ ] Employed full-time[ ] Employed part-time[ ] Migrant Seasonal Farm Worker[ ]  Unemployed (6 months or less)[ ] Unemployed (more than 6 months)[ ] Unemployed (not in labor force)[ ]  Retired[ ]  Unknown/not reported[ ] Youth ages 14-24 who are neither working nor in school | [ ]  Medicaid[ ]  Medicare[ ]  Private/Employment Based[ ]  Self-Insured/Direct Pay[ ]  None[ ]  State Children’s Health Insurance Program[ ]  State Health Insurance for Adults | [ ]  Affordable Care Act Subsidy[ ]  Childcare Voucher[ ]  Housing Choice Voucher[ ]  HUD-VASH[ ]  Other[ ]  Permanent Supportive Housing[ ]  Public Housing[ ]  SNAP[ ]  WIC |
| **First Name** | **M.I.** | **Last Name** |
|  |  |  |
| **Social Security Number** | **Date of Birth** | **Gender** |
|  |  | 🞎 Female 🞎 Other🞎 Male |
| **Ethnicity** | **Race** | **Education** |
| [ ]  Hispanic, Latino or Spanish Origins[ ]  Not Hispanic, Latino or Spanish Origins | [ ]  American Indian/Alaskan Native[ ]  Asian[ ]  Black/African American[ ]  Native Hawaiian/Other Pacific Islander[ ]  Other[ ]  Unknown/Not-reported[ ]  White | [ ]  Grade 0-8[ ]  Grades 9-12/Non-Graduate[ ]  High School Grad/GED[ ]  12+ Some Post-Secondary [ ]  Education[ ]  2 or 4 Year College Graduate[ ]  Graduate or other post-secondary school |
| **Client Disabled?**  | **Military Status** | **Is Client a US Citizen?** |
| [ ]  Yes | [ ]  Veteran[ ]  Active Military  | [ ]  Yes |
| **Work Status** | **Health Insurance Type** | **Non-Cash Benefits** |
| [ ] Employed full-time[ ] Employed part-time[ ] Migrant Seasonal Farm Worker[ ]  Unemployed (6 months or less)[ ] Unemployed (more than 6 months)[ ] Unemployed (not in labor force)[ ]  Retired[ ]  Unknown/not reported[ ] Youth ages 14-24 who are neither working nor in school | [ ]  Medicaid[ ]  Medicare[ ]  Private/Employment Based[ ]  Self-Insured/Direct Pay[ ]  None[ ]  State Children’s Health Insurance Program[ ]  State Health Insurance for Adults | [ ]  Affordable Care Act Subsidy[ ]  Childcare Voucher[ ]  Housing Choice Voucher[ ]  HUD-VASH[ ]  Other[ ]  Permanent Supportive Housing[ ]  Public Housing[ ]  SNAP[ ]  WIC |

|  |
| --- |
| **Countable Income Information** |
| Customer Name: | Total Amount Received | Period Received (30, 90 or 365 days) |
|  | $ |  |
|  | $ |  |
|  | $ |  |
|  | $ |  |
|  | $ |  |
|  | $ |  |
|  | $ |  |
| Income Category: | Frequency: | Total Amount: |
| [ ]  Fixed | [ ]  SSI[ ]  SSDI[ ]  SSA[ ]  Pension[ ]  Window/Widower’s benefit[ ]  Adoption Assistance[ ]  Alimony[ ]  Black Lung pension | [ ]  Weekly[ ]  Bi-weekly[ ]  Monthly[ ]  Yearly | $  |
| [ ]  Earned | [ ]  Wages[ ]  Self-employment[ ]  Active Military Pay[ ]  Ohio Electronic Child care | [ ]  Weekly[ ]  Bi-weekly[ ]  Monthly[ ]  Yearly | $  |
| [ ]  Supplemental | [ ]  Unemployment[ ]  Utility Assistance[ ]  Workers’ Compensation[ ]  Ohio Works First (TANF, ADC) | [ ]  Weekly[ ]  Bi-weekly[ ]  Monthly[ ]  Yearly | $  |
| [ ]  Other | [ ]  Cash withdraws from: IRA, Annuities, Other investments[ ]  Lump sum payout from: SSI, SSDI, Estate & Trust settlements, Divorce settlements, insurance payout, lotter winnings[ ]  Interest Income | [ ]  Weekly[ ]  Bi-weekly[ ]  Monthly[ ]  Yearly | $  |
| [ ]  None | $  |
| **Total:** | $  |
| **Deductions:** |
| Deductible Income:  | Frequency:  | Total Amount: |
| [ ]  Health Insurance Premiums[ ]  Health Care Spending Accounts[ ]  Medicaid Spend Down (deductibles) [ ]  Medicare Part D (RX premium)[ ]  Child Support paid-out[ ]  Attorney fees for estate or trust settlements | [ ]  Weekly[ ]  Bi-weekly[ ]  Monthly[ ]  Yearly | $ |
| **Total Household Income (Countable Income – Deductions)** | $  |
| **Federal Poverty Level:** |  \_\_\_\_\_\_\_% |

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Excluded Income** |
| Excluded Income: | Frequency:  | Total Amount: |
| [ ]  Agency Orange Pension[ ]  Veterans affairs, service related disability[ ]  Handicapped income (i.e. work programs for the blind or disabled)[ ]  Title V wages (i.e. senior employment programs)[ ]  Volunteers in Service to America Stipend (VISTA) [ ]  Work allowances (work requirement to receive OWF assistance)[ ]  Income earned by dependent minors[ ]  Tax refunds/rebates[ ]  Education assistance (grants stipends for tuition/books)[ ]  Stipends for foster care[ ]  Military allowances for subsistence [ ]  Ohio waiver program (Medicaid benefit for caregiver)[ ]  Prevention retention and contingency (i.e. emergency services, rental asst.)[ ]  transportation allowances (WIOA)[ ]  Proceeds from reverse mortgage[ ]  FEMA, cash payments[ ]  Title III Disaster relief emergency assistance | [ ]  Weekly[ ]  Bi-weekly[ ]  Monthly[ ]  Yearly | $  |

|  |
| --- |
| **Expenses:** |
| Expense Type: | Total Monthly Expense amount: |
| Food | $ \_\_\_\_\_\_\_ |
| Shelter | $  |
| Child Care | $  |
| Transportation | $ \_\_\_\_\_\_\_ |
| Utilities | $  |
| Total: | $ \_\_\_\_\_\_\_ |

**Community Services Block Grant Application Details**

|  |
| --- |
| **CSBG Domain (i.e. Employment) Goals** |
| Goal (FNPI): | Member: | Enrollment Date: | Achieved Date: |
| **Demonstrates** |  |  |  |
|  **Improved mental &** |  |  |  |
|  **Behavioral health &** |  |  |  |
|  **Well being** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **CSBG Domain**  |
| Activity/Service (SRV): | Description: | Member: | Quantity:  | Amount: | Date: |
| **Recovery Coaching**  |  |  |  |  |  |
| **Substance Abuse Counseling** |  |  |  |  |  |
| **Narcan Kit** |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Universal Release Form**Consent to Release Non-Protected Information

|  |  |  |
| --- | --- | --- |
| ISSUING AGENCY: |  |  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ |
|   |  |  |
|  |  |  |
| Client Name: \_\_\_\_\_\_\_\_\_\_\_\_ \_  |  DOB: \_\_\_\_\_\_\_\_\_\_\_\_  |  SS#: \_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_ |
| Please indicate “ALL of the Following” or initial the individual agencies you wish to share information. |
| I, hereby authorize:\_\_\_ All of the Organizations Below |
| \_\_\_O.S.U. Extension | \_\_\_ Mental Health | \_\_\_ One-Stop |
| \_\_\_ Early Start | \_\_\_Probate Juvenile Court | \_\_\_ Red Cross |
| \_\_\_ School Districts | \_\_\_Physicians | \_\_\_ Sheriff |
| \_\_\_ Board of MRDD | \_\_\_Community Action | \_\_\_ Police Department |
| \_\_\_ Head Start | \_\_\_ Bureau of Support | \_\_\_ Prosecutor |
| \_\_\_ Job & Family Services | \_\_\_ Recovery Centers | \_\_\_ Victim/Witness |
| \_\_\_ Children’s Services | \_\_\_ Hospital | \_\_\_Adult Probation |
| \_\_\_ Health Department | \_\_\_Domestic Violence Programs | \_\_\_Adult Parole |
| \_\_\_Rehabilitation Services Commission | \_\_\_ Veteran’s Services | \_\_\_VA Chillicothe |
| \_\_\_Vocational/Educational Services | \_\_\_Goodwill Industries | \_\_\_ Commission on Aging |
| \_\_\_ Early Intervention | \_\_\_ Employment Services Program | \_\_\_Alternative School |
| \_\_\_Service Plan Coordinator | \_\_\_ Metropolitan Housing Authority | \_\_\_Nursing Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Legal Services | \_\_\_ Transportation | \_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Family & Children First | \_\_\_ Pregnancy Center | \_\_\_Landlord\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Continuum of Care | \_\_\_Food Pantry \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_CLUSTER |
| \_\_\_Potential Housing Providers | \_\_\_FREE Support Group | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Region 16 Coordinated Intake Partners\_\_\_ Resurrection Recovery Support Group  | \_\_\_ Let Hope Arise Support Group |
| To share such information and/or papers with one another as may be necessary to develop an effective service plan, avoid duplication of services to, and better assess the needs of individuals and families. |
| Such information and/or papers may include: | \_\_\_All of the following | \_\_\_Medical Records |
| \_\_\_Psychotherapy Reports | \_\_\_Psychological Reports | \_\_\_Service Records |
| \_\_\_Scholastic/Attendance Reports | \_\_\_Court Records | \_\_\_Employment Information |
| \_\_\_ Housing Information | \_\_\_Household Service Plans | \_\_\_Individual/Family Referrals |
| \_\_\_Arrearages  | \_\_\_Household Case/Goal Plans  | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_Only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Specify where required by confidentiality laws and regulations.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| By signing this form, I understand that papers may contain private information about me and my children and that I am allowing this information to be shared by those indicated above. I also understand that the information released is protected by State and Federal confidentiality regulations and cannot be disclosed without my written consent. I further understand that I may revoke this consent at any time. This consent expires automatically one year after the day of the signature. |
| Date: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: | \_\_\_Father | \_\_\_Mother | \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| Renewal Date: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: | \_\_\_Father | \_\_\_Mother | \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Revoked Date: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: | \_\_\_Father | \_\_\_Mother | \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*2ND Contact**

**CAC
Authorization to Use and Disclose Protected Health Information**

**NOTICE – PLEASE READ**: I understand that each authorization signed below will remain in effect for **365** days after I sign and date the form, unless otherwise specified. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization. I understand that if I have authorized CAC to disclose my information to person who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to other without my consent or authorization. CAC will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Name: Date of Birth**:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_**

**I hereby authorize the CAC to:**

**[ ]  disclose information** **[ ]  request information** **[ ]  exchange information**

With Name of Person or Entity:

Address:

Telephone/Fax:

**INFORMATION TO BE USED/DISCLOSED**

**Initial the following items needed:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Diagnostic Assessment/ Intake |  | Psychological Evaluation Reports |  | Treatment Plan/ISP |
|  | Progress Notes |  | Psychiatric Evaluation |  | Other Social History |
|  | Physician’s Orders |  | Court Reports/Records |  | Medication Records |
|  | School Records/ Consultation |  | Laboratory Reports |  | Employment Records/Reports |
|  | **HIV and AIDS Status** |  | **Drug and Alcohol Addiction Records** |  |  |

Other (CLEARLY SPECIFY)

Purpose for Disclosure: [ ]  Assist in Treatment Planning [ ]  Continuity of Care

[ ]  Other (Specify)

I understand that my mental health and alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This consent will expire at (Event) **OR**

when (Condition) **OR** on \_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_whichever occurs first, not to exceed 365 days.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice To Recipient Of Information**: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules **prohibit the recipient of the protected health information from making further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

**NOTICE OF REVOCATION**

I hereby, revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Client/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Revoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE OHIO STATE OPIOID RESPONSE GRANT (SOR) Consent to Participate**

You have been identified as a potential participant in the SAMHSA funded State Opioid Response Grant. As a result, you may be eligible for certain substance use treatment and support services offered through this project. Your participation is voluntary.

**Background Information:** The SOR Program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is being administered by the Ohio Department of Mental Health and Addiction Services (OhioMHAS). Wright State University will be providing oversight of the SOR data collection and follow-up evaluation. The purpose of this project is to address the unique needs of individuals living with a substance use issue living in the community; and to determine through an evaluation process if selected treatment and support interventions impact participant wellness and success within the community.

**Procedures:** While enrolled in the SOR program, we may ask you to participate in the following things:

1. On-going assessments to assist you in determining your treatment and support needs and to develop and monitor your individualized case plan.

2. Three confidential interviews, at the beginning of the program, at six months into the program and at its completion. Each interview will last approximately 20-30 minutes and will occur at a mutually agreed upon location and time. You will be asked questions about your satisfaction with the services that have been provided and about various aspects of your life, including your housing, health, mental health, employment, criminal justice involvement, and overall functioning.

3. We will be using the data we collect from you to evaluate if participants’ qualifying condition and quality of life improves as a result of the program. For your participation in the data collection, you will be compensated with a $10 gift card for the initial/baseline interview and a $20 gift card for the 6-month follow-up interview. We are asking that you provide contact information on a Locator Form so that we can send the gift card to you for the initial interview and to contact you when it is time for your 6-month follow-up interview. Upon completion of the 6-month follow-up interview, we will review and update, if necessary, the locator form in order to send your gift

card. You will receive each gift card within two weeks of your interview, and a member of the SOR Evaluation team will mail the gift card to you from Wright State University. Completion of the Locator Form is part of your agreement to consent to participate in the SOR program evaluation.

4. Your participation in the evaluation component of the program is voluntary. You are free to refuse to participate in the interview(s), to decline to answer any question(s), or to terminate the interview at any time. You understand that if you take any of these actions they will in no way influence the provision of any services that you may be receiving or am eligible to receive

through the SOR Program. If you decide you do not want to participate any longer in the evaluation survey, you can tell the interviewer directly or tell your treatment provider.

**Risks and Benefits to participating in SOR services and study:** Potential risks for participating in this study are minimal and include the potential for psychological distress due to the nature of the information being shared. You are under no obligation to answer any question put forth nor will your responses be linked to your identity in any records. Although every step is taken to maintain confidentiality, the risk of breach of confidentiality exists.

**Who is collecting the information:** Any information about you obtained through the interviews is strictly confidential and is available only to program staff collecting the information and staff at OhioMHAS and Wright State University who are responsible for monitoring and evaluating the program. You will never be identified in any report or publication.

**Confidentiality:** You understand the information collected about you will be kept confidential. You will never be personally identified in any report, publication, or to any law enforcement or criminal justice agency with the following exceptions: admitting or threatening homicide on a particular individual, threatening suicide, or admitting or threatening child abuse. If you make such a threat, you will be reported to the appropriate law enforcement authorities.

1. You understand that project staff will report cases of child abuse to the appropriate agencies and I

would be identified if I were involved in such cases.

2. If you threaten suicide, that threat will be assessed by project staff and, if warranted, you will be reported to the appropriate mental health authorities.

In Addition:

**√**All assessment responses that you provide will only be used to assist you in addressing your short and long term recovery support needs. It will not be shared with anyone without your written, informed consent.

**√**Service evaluation information will go directly to the evaluation associate (GPRA data collector). Your responses, if collected by paper and pencil, will be kept in a locked file cabinet. To keep your answers private, your name will not appear anywhere on the interview. We will use a number instead of your name. Your answers to the questions will be put together with many other people’s answers and there will be no way to know whose answers are whose. In any report we might publish, we will not include any information that will make it possible to identify you. Access to the records will be limited to the project staff.

**Statement of Understanding and Consent**

[ ]  I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

[ ]  I have read the above information. I have received answers to questions I have asked.

[ ]  I agree to participate in the SOR Program.

[ ]  I consent to participation in SOR Program confidential surveys and program evaluation and I

am at least 18 years of age.

[ ]  I agree to share information regarding my treatment and services I receive as a result of this grant.

[ ]  I have been provided a copy of this form.

Signature Date

Witness Date

**Consent for Services and Participation Agreement**

CAC offers care coordination and transportation for households (individuals or families) experiencing OUD. Participants agree to participate in monthly appointments, provide required documentation, and work to reach their goals in order to reach sobriety. The purpose of this agreement is to state the terms and conditions under which the CAC RHOP services will be provided to program participants. This agreement will also detail the responsibilities of program participants, and what may result in termination of PSH assistance.

|  |
| --- |
| ***Consent for Services*:** **I agree to participate in the RHOP program and understand it is a program that consists of a combination of transportation and supportive services. I understand the ultimate goal of the program is to enable each participant to be able to maintain their selected treatment program, sobriety and to increase stability. I agree to participate in monthly or as needed appointments and will submit required program documentation. I understand that I may withdraw from the program at any time and agree to meet with my Peer Support Specialist to close my household’s case.****Participant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.**If the participant is under 18, parental consent is required:**I, Click or tap here to enter text., give permission to my dependent to receive services from the RHOP program. This consent was given Click or tap to enter a date..  |

**Participation Agreement**

I understand and agree to adhere to all the guidelines stated herein which have been fully discussed with me and agree to voluntarily sign this contract. I also agree to truthfully report any problems, changes, or concerns that occur during the length of involvement with the program. I further understand that my active participation in the program services allows the Peer Support Specialist to support my ability to participate in treatment services and to overcome barriers to my sobriety, well-being and overall stability.

***Participant Responsibilities/Obligations:***

1. I understand that I ***must develop a Care Plan (ISP)*** with my Peer Recovery Specialist \_\_\_\_\_\_\_\_ (Initials)

2. I understand that the total length of services depends is determined on a case by case basis. Factors affecting the length of services include; needs of the household, household engagement in services, and available resources. \_\_\_\_\_\_\_\_ (Initials)

3. I agree to participate in the program’s supportive services that best fit my needs. The options for services includes: transportation, case management, care coordination, facilitating transitions across settings, linkage to community resources, patient support and engagement, creating care plans, referrals to treatment, after treatment planning, preparing individuals for treatment, and assist participants in maintaining treatment and/or finding a treatment method better suited to participant needs. I agree to allow the Recovery Specialists to release information about myself/household to providers in an effort to assist my household in increasing stability and sobriety. My Specialist will only release information for the purposes of assisting my household with the exception of mandatory reporting. \_\_\_\_\_\_\_\_ (Initials)

5. I understand that I need to report changes of treatment participation. I agree to keep my Case Manager informed & updated on my stability needs. \_\_\_\_\_\_\_\_ (Initials)

6. I understand I am required to contact and/or meet with my Peer Recovery Specialist every 30 days. I understand that I will notify staff if I have a conflict with an appointment time, and if I repeatedly miss and/or cancel appointments, and do not utilize services, the Peer Recovery Specialist may discuss my exit from the program. I understand that I will need to meet with staff to review my exit strategy. I have the right to appeal this exit if desired. \_\_\_\_\_\_\_\_ (Initials)

10. I understand that I must maintain the confidentiality of all program participants. \_\_\_\_\_\_\_\_ (Initials)

***Termination of Assistance***

If the participant at any time decides not to follow this agreement, the program may recommend ending the assistance for the participant. If the participant is nonresponsive, program staff must make three attempts to contact them. The three attempts should not be using the same method. The termination process may include, but is not limited to:

1. Written/verbal notice to the participant detailing reasons for termination:
	1. Not following program agreement
	2. Participant request to withdraw from CAC program

If I do not agree with the reasons for termination I may follow the grievance process:

***Grievance Process***

There are three (3) steps to the grievance process:

1. Discuss the matter with a staff member involved. Frank discussion will usually clear up the misunderstanding and solve the problem. If the matter remains unresolved, go to the next step.

2. Request a complaint form and complete it. Forward the report to the RHOP Program Co-Director**,** 1400 U.S. Route 22 NW Washington Court House, OH 43160. If you are unable to fill out the complaint form, you may request a meeting with the Co-Director. She/He will review the complaint and respond in writing to the participant within five (5) working days of receipt of the report. If the participant remains dissatisfied with the resolution offered, she/he may take the next step. \*\* Or in the case that the grievance is with the Co-Director, move to step 3.

3. Request that the complaint form be forwarded to the RHOP Director for review. She/He will take one of the following two (2) steps:

* + - Give the participant a written response which would indicate the final disposition; or
		- Call a conference for the parties involved in the incident(s). The final disposition will be issued within five (5) working days of the conference.

If the decision is not satisfactory, you may file a request for an administrative appeal. Submit your written appeal, along with the response of the agency to **Bambi Baughn, Executive Director of Community Action.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap to enter a date.
 **Participant (HoH) Signature**  **Date**(Provide copy)

**CAC Confidentiality Agreement**

***Confidentiality is protecting another person’s right to privacy***Information clients reveal to their Peer Recovery Specialist (PRS) will not be discussed with anyone else. This means that the PRS will not reveal a client’s personal information to anyone, without client’s written permission, unless required by law.

***A Release of Information*** form is used to obtain this permission between the staff and client. This Confidentiality Agreement form serves as the permission between the staff and client to allow PRS to meet, get acquainted, and discuss social and personal interests that a client reveals with other community and social service providers and program evaluators.

***Exceptions to the Right of Confidentiality***PRS have to report information that is required by Federal or State law. This includes information that indicates a participant is endangered, exploited, or is related to suspected fraudulent activity or other violations of the law.

***Confidentiality Pledge***As your Peer Recovery Specialist, I agree to protect your right to privacy and confidentiality. I will not disclose any information about you unless I am required to do so by law or authorized to do so through your signed release.

**Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

 **Peer Support Specialist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

**Strengths/Challenges Assessment Form**

**Participant (HOH) Name:** Click or tap here to enter text. **Date:** Click or tap to enter a date.

Describe a time when you were doing well in life and were not abusing drugs and/or alcohol.

Click or tap here to enter text.

Who or what (resources, circumstances, etc.) was in your life that made that possible?

Click or tap here to enter text.

What services or programs do you think will help you create a similar situation?

Click or tap here to enter text.

What expectations do you have for your participation in our program? What are your goals for participation?

Click or tap here to enter text.

What challenges will you face and what might help you overcome those challenges?

Click or tap here to enter text.

What are your personal strengths? What can we do to capitalize on those to help you meet your goals?

Click or tap here to enter text.

**Participant (HoH) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

 **Peer Support Specialist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

**Discharge Planning**

**Needs Plan Outcome**

[ ]  Treatment Plan Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Housing Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Employment Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Income Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Education Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Medical Issues Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Legal Issues Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Financial Concerns Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Community Involvement Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Benefit Planning Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Transportation Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Obstacles to Recovery Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Obstacles to Recovery Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Obstacles to Recovery Click or tap here to enter text. Met: Click or tap to enter a date.

[ ]  Obstacles to Recovery Click or tap here to enter text. Met: Click or tap to enter a date.

What does success look like? What will have been met prior to my discharge from Pathways to Recovery?

Click or tap here to enter text.

**Referral Tracking Form**

|  |
| --- |
| Participant Name:Click or tap here to enter text. Date:Click or tap to enter a date. |
|  |  |  |  |  |
|  | Service | Provided/Referred(Check) | Agency or Service |
|  |  Furniture Assistance | [ ] Provided [ ] Referred |  |
|  |  Utility Assistance | [ ] Provided [ ] Referred |  |
|  |  Food Pantry | [ ] Provided [ ] Referred |  |
|  |  Clothing/Furniture Voucher | [ ] Provided [ ] Referred |  |
|  |  Job Training/ Placement Referral | [ ] Provided [ ] Referred |  |
|  |  Schooling/ Training | [ ] Provided [ ] Referred |  |
|  |  Mental Health Counseling | [ ] Provided [ ] Referred |  |
|  |  PRC Assistance | [ ] Provided [ ] Referred |  |
|  |  EF&S Application/ Assistance | [ ] Provided [ ] Referred |  |
|  |  Metropolitan Housing | [ ] Provided [ ] Referred |  |
|  |  Landlord Advocacy | [ ] Provided [ ] Referred |  |
|  |  Budget Counseling | [ ] Provided [ ] Referred |  |
|  |  Eviction Prevention Information | [ ] Provided [ ] Referred |  |
|  |  Lease Review | [ ] Provided [ ] Referred |  |
|  |  Head Start/Help Me Grow | [ ] Provided [ ] Referred |  |
|  |  Jobs & Family Services | [ ] Provided [ ] Referred |  |
|  |  Salvation Army | [ ] Provided [ ] Referred |  |
|  |  Youth Build | [ ] Provided [ ] Referred |  |
|  |  Social Security | [ ] Provided [ ] Referred |  |
|  |  Substance Abuse Counseling | [ ] Provided [ ] Referred |  |
|  |  Child Care Assistance (Title 20) | [ ] Provided [ ] Referred |  |
|  |  After-School/ Summer Camp Program  | [ ] Provided [ ] Referred |  |
|  |  Other | [ ] Provided [ ] Referred |  |

**Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

 **Peer Support Specialist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

|  |
| --- |
| Case Plan |
| Participants Name: |
| Recovery Coach Name:  |
|  |
| This individualized plan should be developed in partnership between the Recovery Coach and the participant. Goals should be identified by the participant and agreed upon by both parties. Please ensure that each Objective meets “SMART” goal format (Specific, Measurable, Achievable, Realistic, and Time-Limited). Update the plan continually and start a new form/ Plan as goals are achieved.  |
| GOAL 1: Choose an item. Click or tap here to enter text. |
| SMART Action Steps to Complete Goal | Participant ResponsibilityAction Steps | Worker ResponsibilityAction Steps | TargetDate | DateAchieved |
| Objective 1 |  |  |  |  |
| Objective 2 |  |  |  |  |
| GOAL 2: Choose an item. Click or tap here to enter text. |
| Objective 1 |  |  |  |  |
| Objective 2 |  |  |  |  |

**Treatment History**

1. Outpatient Therapy

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date** | **End Date** | **Provider Name/Location** | **What worked or didn’t work for you about the program? Did you successfully complete?** |
| Click or tap to enter a date. | Click or tap to enter a date. |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Inpatient Treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date** | **End Date** | **Provider Name/Location** | **What worked or didn’t work for you about the program?** |
| Click or tap to enter a date. | Click or tap to enter a date. |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Medication Assisted Treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date** | **End Date** | **Provider Name/Location** | **What worked or didn’t work for you about the program?** |
| Click or tap to enter a date. | Click or tap to enter a date. |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Detox

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date** | **End Date** | **Provider Name/Location** | **What worked or didn’t work for you about the program?** |
| Click or tap to enter a date. | Click or tap to enter a date. |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Hospitalization (Mental Health or Substance Abuse)

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date** | **End Date** | **Provider Name/Location** | **What worked or didn’t work for you about the program?** |
| Click or tap to enter a date. | Click or tap to enter a date. |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Care Coordination**

|  |  |  |
| --- | --- | --- |
| **Services** | **Complete** | **Date** |
| **Screened for Opioid Use Disorder** |[ ]  Click or tap to enter a date. |
| **Identified as having Opioid Use Disorder** |[ ]  Click or tap to enter a date. |
| **Referred to treatment provider** |[ ]  Click or tap to enter a date. |
| **Attended consultation and began treatment** |[ ]  Click or tap to enter a date. |
| **Remained in treatment for 0-2 months** |[ ]  Click or tap to enter a date. |
| **Remained in treatment for 3-5 months** |[ ]  Click or tap to enter a date. |
| **Remained in treatment for 6-12 months** |[ ]  Click or tap to enter a date. |
| **Remained in treatment for over one year** |[ ]  Click or tap to enter a date. |
| **Notes:** |

**Care Coordination Service Notes**

|  |  |  |
| --- | --- | --- |
| **Date** | **Service** | **Notes** |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |
| Click or tap to enter a date. | Choose an item. |  |

**Care Coordination Programs Enhanced/Created
Peer Support Staff should utilize this space to log information on the client’s treatment and/or peer support activities that were enhanced or created by this project. (Staff should ask the client about their participation in treatment and NA/AA meetings at each visit.)**

|  |  |  |
| --- | --- | --- |
| **Date** | **Service** | **Notes** |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |
|  | Choose an item. |  |

**Optional Using Behavior Analysis
**

**Client Survey**

**Age:**\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Peer Recovery Supporter Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you feel that you were treated with dignity and respect during the program? [ ]  Yes [ ]  No
Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. True or False, I feel that I had choices presented to me during my program stay and staff presented me with options.
[ ]  True [ ]  False Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Were services tailored to your needs? For example, when you needed extra help, staff was available and when you needed time, staff checked in with you monthly. [ ]  Yes [ ]  No Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. True or false, I would recommend this program to others. [ ]  Yes [ ]  No
5. Please describe the types of assistance you received from your Peer Recovery Specialist. Which did you value the most? What could you have done without?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there anything else you want us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Monthly Case Planning Visit**

Client Entry Date: Client Treatment Start Date:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Checklist | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
| How long has the client been in treatment uninterrupted? |  |  |  |  |  |  |  |  |  |  |  |  |
| How long has the client been in a treatment program total? |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you updated the referral form this month? |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you updated the case plan this month and documented goals met/revised? |  |  |  |  |  |  |  |  |  |  |  |  |
| Did the client attend any behavioral health counseling this month? If yes, how many times since your last visit and where? |  |  |  |  |  |  |  |  |  |  |  |  |
| Did the client attend any support groups this month? If yes, how many times since your last visit and where? |  |  |  |  |  |  |  |  |  |  |  |  |
| Can the client verbalize any pro-social involvement? |  |  |  |  |  |  |  |  |  |  |  |  |
| Is client employed or attending some type of education programming? |  |  |  |  |  |  |  |  |  |  |  |  |
| Does the client have safe affordable housing? |  |  |  |  |  |  |  |  |  |  |  |  |
| Has the client improved any of their social determinants of health? (refer to discharge planning) |  |  |  |  |  |  |  |  |  |  |  |  |
| Have they maintained sobriety? |  |  |  |  |  |  |  |  |  |  |  |  |

Use the space below for notes on outcomes and improvements:

**Transportation Referral Form**

**First Name:** Click or tap here to enter text. **Last Name:** Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date.

**Marital Status:** Choose an item. **Ethnicity: Disability:** [ ] **Visual** [ ] **Mental** [ ] **Physical**

**Home Address:** Click or tap here to enter text.

**Home Phone: Mobile Phone:**

**Emergency Contact (name, phone and relationship):**

**Transportation Needs:** [ ] **Treatment** [ ] **Work** [ ] **Shopping** [ ] **Benefit(s) Appointments**

**Does the client have anyone that could take them, but they lack the financial ability to provide transportation?** Choose an item.

**Is the client on Medicaid?** Choose an item. **If yes, do they have a managed care provider? Please select if yes**: Choose an item.

**If the client is going to physician’s office, please insert the name of the physician and their phone number in the space below:**

Click or tap here to enter text.

**Does the client have any mobility or health related devices? If yes, please select**:

[ ] **wheelchair** [ ] **walker** [ ] **cane Please describe any other mobility devices and the size of the device:** Click or tap here to enter text.

**Does the client have an emergency contact? Please insert their name, relationship and phone number below:**

Click or tap here to enter text.

Is this client approved to have their transportation paid for out of the Pathways to Recovery grant? [ ]  **Yes** [ ]  **No**

Transportation Rules: 24 hour notice, drivers wait only 3 minutes, double check your addresses and dispatch will give you a 30 minute window. The client must be ready to leave at any time within that window.

 **Case File**

|  |  |  |
| --- | --- | --- |
|  | **Date Completed** | **Initials of Staff Person Completing**  |
| **Initial Referral** |
| Initial Program Evaluation Form |  |  |
| RHOP Target Population & OUD Verification Form |  |  |
| **Program Enrollment/Acceptance of Services** |  |  |
| CSBG Enrollment |  |  |
| Fayette County Universal Release Form |  |  |
| SOR GPRA Consent Form |  |  |
| Consent for Services and Participation Agreement  |  |  |
| Confidentiality Agreement |  |  |
| Referral Tracking Form |  |  |
| Strengths and Challenges Assessment |  |  |
| Care/Service Plan |  |  |
| Treatment History |  |  |
| Optional Using Behavior Analysis |  |  |
| Client Exit Survey |  |  |
| Monthly Case Planning Visit |  |  |
| Transportation Referral |  |  |
| Discharge Form |  |  |

# Pathways Discharge Form

Client Name: Click or tap here to enter text. Date of Discharge: Click or tap to enter a date.

Reason for Discharge: Choose an item.

Living Arrangements: Choose an item. Employment Status: Choose an item.

Primary Income Source: Choose an item. Annual Income: Click or tap here to enter text.

**Assessment Point in Time:** – Choose an item. If you selected other, specify here: Click or tap here to enter text.

**SAMHSA National Outcomes -**
A. Getting and keeping a job or enrolling and staying in school. Staff will assess increases in income, employment and education throughout the program.

1. Income: Choose an item.
2. Employment: Choose an item.
3. Education: Choose an item.

B. Finding safe and stable housing. Staff will assess housing stability throughout the program.

1. Shelter: Choose an item.

C. Reduced symptoms from mental illnesses during the program will be assessed.

1. Mental Health: Choose an item.

D. Decreasing involvement with the criminal justice system. Staff will assess involvement throughout the program.

1. Involvement with Criminal Justice System: Choose an item.
2. Improving social connectedness to others in the community. Staff will assess community involvement throughout the program.
3. Community Involvement: Choose an item.
4. Increased access to services. Staff will assess the increase in mainstream benefits during the program.
5. Food: Choose an item.
6. Health Care: Choose an item.
7. Transportation: Choose an item.
8. Abstinence from drug and/or alcohol use and retention in treatment
9. Substance Abuse: Choose an item.
10. Retention in Treatment Services: Choose an item.
	1. Regardless of length of treatment, did the client finish the treatment program during their program stay? [ ]  Yes [ ]  No

Total Score:

(Staff, add the numerical value of each question to determine the score)

In the space below, please describe the client’s success story and/or any recommendations for future engagement of the client:

|  |
| --- |
|  |

In the space below, please note client comments at discharge:

|  |
| --- |
|  |

Immediate and long term after care plans:

|  |
| --- |
|  |