DRUG AND ALCOHOL TREATMENT INFORMATION FORM

CASE IDENTIFICATION			
CO	DIST	RECORD #	DATE

FIRST	LAST			M.I.	SOCIAL SECURITY NUMBER
STREET NAME #	APT. #	CITY	STATE	ZIP CODE	TELEPHONE NO. ( )

TREATMENT CENTER AND ADDRESS:

☐ **REFERRAL**

This person is being referred for evaluation of a possible alcohol or drug abuse problem and possible entry into a treatment program. The clinic evaluation will assist the county assistance office (CAO) in determining this person's eligibility for assistance. Please provide information below or on the reverse as requested. If necessary, copy for your records and return the original copy to the presenter, or mail to:

CAO ADDRESS: _____

_____ _____

IMCW NAME

أصرح بموجبه وأطلب الإفصاح عن المعلومات بواسطة مركز علاج الكحول/المخدرات خاصتي إلى CAO للتحقق من كوني خاضعا في الوقت الحالي لعلاج تعاطي المخدرات/ الكحول، مع التحقق من اسم وعنوان برنامج علاج المخدرات/ الكحول، والفترة المقدرة للعلاج، و نوع العلاج، وما إذا كان برنامج العلاج يعوقني عن أي شكل من أشكال العمل، وأي معلومات ذات صلة بالقدرة على العمل وبالعلاج مطلوبة في هذا النموذج. أنا أتفهم أن المعلومات التي تم الحصول عليها لن تستخدم إلا لأغراض تتعلق مباشرة بأهليتي للحصول على المساعدة لمدة من العمر تصل إلى تسعة أشهر. كما أتفهم أن هذا التصريح يمكن إلغاؤه بواسطتي في أي وقت إلا في حدود ما تم التصرف فيه، ولكنه سينتهي بعد تسعة أشهر من تاريخ توقيعي أو في تاريخ _____ إذا كان ذلك قبل تسعة أشهر.

I hereby authorize and request disclosure of information by my drug/alcohol treatment center to the CAO verifying that I am currently undergoing treatment for drug/alcohol abuse, the name and address of the drug/alcohol treatment program, the estimated length of the treatment, the type of treatment, whether the treatment program precludes me from any form of employment, and any related employability and treatment information requested on this form. I understand that the information obtained will be used only for purposes directly related to my eligibility for assistance for up to a lifetime limit of nine months. I also understand that this authorization can be revoked by me at any time except to the extent it has been acted upon, but will otherwise expire nine months after the date of my signature or on _____ if sooner than nine months.

_____ _____

APPLICANT/RECIPIENT SIGNATURE • توقيع مقدم الطلب/المستفيد DATE • التاريخ

_____ _____

WITNESS SIGNATURE • توقيع الشاهد DATE • التاريخ

_____

TITLE • الوظيفة

يقتضي القسم رقم 62 من القانون رقم 432 الفقرات (3)(C)(i) و (E) والقسم رقم 55 من القانون رقم 141.61 الفقرة (E)(iii)(1)(c) بأنه يجب على هذا الشخص، كشرط من شروط الأهلية للحصول على المساعدات، أن يحافظ على أي موعد مجدول وأن يقبل أي علاج يوصف له إذا ثبت للتقييم أن لديه مشكلة تتعلق بتعاطي الكحول أو المخدرات، وأن برنامج العلاج الخاص به يعوق أي شكل من أشكال العمل.

62 P.S. §432(3)(i)(C) and (E) and 55 Pa. Code §141.61 (c)(1)(iii)(E) require that, as a condition of eligibility for assistance, this person must keep any scheduled appointment and accept whatever treatment is prescribed for him/her if an evaluation substantiates that he/she has an alcohol or drug problem, and his/her treatment program precludes any form of employment.

PROVIDER RESPONSE TO REFERRAL

☐ SLOT AVAILABLE. START DATE _____ ESTIMATED LENGTH OF TREATMENT PERIOD _____

☐ OUTPATIENT/INTENSIVE OUTPATIENT* ☐ PARTIAL HOSPITALIZATION ☐ RESIDENTIAL/HALFWAY HOUSE

TREATMENT SCHEDULE _____

☐ DOES THE TREATMENT SCHEDULE PRECLUDE THE CLIENT FROM WORKING? ☐ YES ☐ NO

IF YES, WHY? _____ IF YES, WHEN WILL HE/SHE BE ABLE TO WORK? _____

*SCA SIGNOFF REQUIRED IF TREATMENT SCHEDULE REFLECTS 10 HOURS OR LESS PER WEEK BUT PRECLUDES EMPLOYMENT.

☐ SLOT UNAVAILABLE. DATE FIRST SLOT AVAILABLE _____

☐ CLIENT DID NOT KEEP APPOINTMENT.

☐ REQUEST FOR INFORMATION:

This person has indicated that he/she is currently in a drug/alcohol treatment program. He/she must actively continue in the treatment program to be eligible for assistance. Please provide the information under the sections that are indicated. See the authorization for disclosure of information section above or attached.

☐ INITIAL REQUEST (FIRST MONTH)

☐ CLIENT IS IN ACTIVE TREATMENT. THE TREATMENT BEGAN _____ AND IS EXPECTED TO END _____

THE TREATMENT PROGRAM IS: _____

☐ OUTPATIENT/INTENSIVE OUTPATIENT* ☐ PARTIAL HOSPITALIZATION ☐ RESIDENTIAL/HALFWAY HOUSE

☐ HOW MANY HOURS, PER WEEK, IS THE CLIENT SCHEDULED TO ATTEND TREATMENT? (NOT APPLICABLE TO RESIDENTIAL/HALFWAY HOUSE) _____

☐ DOES THE TREATMENT PROGRAM PRECLUDE THE CLIENT FROM WORKING? ☐ YES ☐ NO

IF YES, WHY: _____ IF YES, WHEN WILL HE/SHE BE ABLE TO WORK? _____

*SCA SIGNOFF REQUIRED IF TREATMENT SCHEDULE REFLECTS 10 HOURS OR LESS PER WEEK BUT PRECLUDES EMPLOYMENT.

☐ PROGRESS REPORT: PERIOD BEGINNING/ENDING: _____ / _____

PROVIDER RESPONSE:

☐ CLIENT REMAINS IN TREATMENT. ☐ YES ☐ NO

CLIENT ATTENDED _____ TREATMENT SESSIONS DURING THE REPORT PERIOD.
NUMBER

☐ DOES THE TREATMENT PROGRAM CONTINUE TO PRECLUDE THE CLIENT FROM WORKING? ☐ YES ☐ NO

IF YES, WHY: _____ IF YES, WHEN WILL HE/SHE BE ABLE TO WORK? _____

☐ TREATMENT PROGRAM ENDED _____. REASON: _____

_____

PLEASE ATTACH ANY ADDITIONAL EXPLANATORY NOTES THAT YOU MAY THINK NECESSARY.

CERTIFICATION: I HEREBY CERTIFY THAT THE INFORMATION PRESENTED IN THIS REPORT IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE DATE

SIGNATURE SCA REPRESENTATIVE (IF NECESSARY)

NAME (PRINT OR TYPE)

NAME (PRINT OR TYPE)

TITLE

SCA DATE

FACILITY NAME