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

我在此请求药物/酒精治疗中心向 CAO 披露我的信息，并为其提供授权，以供CAO 核查我正在进行的滥用药物/酒精的治疗情况、药物/酒精治疗项目的名称和地址、预计的治疗时间、治疗类型、治疗项目是否不准我参加任何形式的职业活动，以及依照这个表格所请求的一切与就业能力和治疗方案相关的信息。我了解获得的信息将仅用于与我所获得的最长九个月援助之资格直接相关的用途，也知道除非在一定程度上该方案已经实施，我可随时取消这份授权，但该授权将在我的签名日期起九个月后失效，或如果早于九个月，则截止日期为： _____ 。

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.

_____ _____

申请人/接受者签名 • APPLICANT/RECIPIENT SIGNATURE　　日期 • DATE

_____ _____

见证人签名 • WITNESS SIGNATURE　　日期 • DATE

_____

职位 • TITLE

依照 62P.S.§432(3)(i)(C)、(E)和55Pa.法案§141.61(c)(1)(iii)(E)要求，作为获得援助的合格条件之一，如果有评估证实他/她存在酒精或毒品问题，此人必须保持一切预定的约定，接受为他/她安排的一切治疗，并且他/她的治疗项目排除了任何形式的工作。

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

NAME (PRINT OR TYPE)

TITLE

FACILITY NAME

SIGNATURE SCA REPRESENTATIVE (IF NECESSARY)

NAME (PRINT OR TYPE)

SCA DATE