

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 _____

Настоящим я даю разрешение и прошу медицинский центр, где я прохожу лечение наркотической/алкогольной зависимости, раскрыть CAO информацию, подтверждающую что в настоящее время я прохожу лечение от злоупотребления наркотиками/алкоголем, название программы лечения наркотической/алкогольной зависимости и адрес, примерную продолжительность лечения, вид лечения, информацию о том, допускает ли моя программа лечения какую-либо форму трудоустройства, а также любую связанную с этим информацию о способности к трудоустройству и лечению, запрашиваемую в настоящей форме. Я понимаю, что полученная информация будет использоваться только для целей, непосредственно относящихся к установлению мой правомочности на получение помощи, в течение девяти месяцев. Я также понимаю, что я могу аннулировать данное разрешение в любое время, за исключением случаев, когда на его основании уже были предприняты действия, однако в противном случае срок действия данного разрешения истечет через девять месяцев с момента его подписания мною или _____ если эта дата наступит раньше, чем через девять месяцев.

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.

ПОДПИСЬ ЗАЯВИТЕЛЯ/ПОЛУЧАТЕЛЯ • APPLICANT/RECIPIENT SIGNATURE ДАТА • DATE

ПОДПИСЬ СВИДЕТЕЛЯ • WITNESS SIGNATURE ДАТА • DATE

ДОЛЖНОСТЬ • TITLE

Согласно требованиям Неофициального свода законов штата Пенсильвания 62 P.S. §432(3)(i) (C) и свода законов штата Пенсильвания (E) и 55 Pa. Code §141.61 (c)(1)(iii)(E), для соответствия критериям на получение помощи данное лицо обязано являться на все назначенные приемы и соглашаться на все предписанное лечение, если по итогам оценки подтвердится что у него имеется проблема с алкоголем или наркотиками и что его программа лечения не допускает никакую форму трудоустройства.

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