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

Por la presente autorizo y solicito la divulgación de información por parte de mi centro de tratamiento de drogas/alcohol a la oficina de asistencia del condado con el propósito de verificar que actualmente estoy recibiendo tratamiento para el abuso de drogas/alcohol, el nombre y la dirección del programa de tratamiento de drogas/alcohol, la duración estimada del tratamiento, el tipo de tratamiento, si el programa de tratamiento me impide cualquier forma de empleo, y cualquier información relacionada con mi tratamiento y mi capacidad para conseguir y mantener empleos, solicitada en este formulario. Entiendo que la información obtenida se utilizará únicamente para los fines directamente relacionados con mi elegibilidad para recibir asistencia por hasta un límite de tiempo de nueve meses. También entiendo que esta autorización puede ser revocada por mí en cualquier momento, excepto en la medida en que se ha actuado, pero de lo contrario expirará nueve meses después de la fecha de mi firma, o el _____ si es antes de nueve meses.

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.

_____ _____

FIRMA DEL SOLICITANTE/BENEFICARIO • APPLICANT/RECIPIENT SIGNATURE — FECHA • DATE

_____ _____

FIRMA DEL TESTIGO • WITNESS SIGNATURE — FECHA • DATE

_____

TÍTULO • TITLE

62 P.S. §432(3)(i)(C) y (E) y 55 Pa. Code §141.61 (c)(1)(iii)(E) exigen que, como condición de elegibilidad para recibir asistencia, esta persona debe mantener cualquier cita programada y aceptar cualquier tratamiento que le sea prescrito, si una evaluación confirma que él/ella tiene un problema de alcoholismo o drogadicción, y su programa de tratamiento excluye cualquier forma de empleo.

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