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Recovery House Referral Packet

Please include the following:

- Completed *Recovery House Referral Form*
- Completed *Release of Information*
- A list of the Client's *medications*
- Copy of Client's *ID* OR a statement of where you are in the process of obtaining one
- Copy of Client's *aftercare plan*
- Client's acknowledgment of COVID protocols
- Active Allegany Insurance
- A *letterhead stating* that the client is appropriate for this level of care.

Before admission client must have outpatient drug and alcohol, mental health, and MAT appointments set up if applicable

Please make the Client aware of the following:

- The Client is limited to 2 bags of clothes and a bag for paperwork and hygiene items. Please make arrangements for the Client's other belongings prior to coming to Recovery House.
- The Client is expected to engage in recovery-oriented activities, employment volunteering, etc.
- The Client understands COVID-19 will have an effect on their stay (see COVID-19 Rules).
- The Client is responsible for their recovery, and how well they do it depends on how much they do.

______________________________ ______________

Client signature **Date**

______________________________ ______________

Referral signature **Date**

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RECOVERY HOUSE REFERRAL FORM

REFERRAL SOURCE INFORMATION (PLEASE PRINT OR TYPE)

Date of Referral:	**Referral Agency:**
Referral Contact Name:	
Contact number:	**Email:**
IDC-10 CODE.:	
Anticipated date of Admission:	

CLIENT'S INFORMATION:

Client Name:	
SSN:	**Date Of Birth:**
Is the Client an Allegheny County Health Choices member?: ☐ Yes ☐No	
Does the Client have an ID?: ☐ Yes ☐No **If no, does the Client have a birth certificate?:** ☐ Yes ☐No	
List Clients current medications:	
Does the client have a Medical Marijuana Card? ☐ Yes ☐No *Please note that a Medical Marijuana Card is not acceptable for Recovery House Program.*	
Is the Client pregnant? If yes, what is her due date? ☐ Yes ☐No	
What is the Client's plan for income?	
Does the Client have pending charges?: ☐ Yes ☐No	
Does the Client have any physical problems?: ☐ Yes ☐No **Please List:**	
Does the Client have Mental Health issues?: ☐ Yes ☐No **Please list:**	
Is the Client an overdose survivor or IDU user?: ☐ Yes ☐No	
Is the Client appropriate for outpatient (LOC)?: ☐ Yes ☐No	
Does the Client have an aftercare plan? : ☐ Yes ☐No	
Does Client need housing: ☐ Yes ☐No **(for planning purposes only)**	
What would the Client want to work on at the Recovery House:	
Does the Client have a Probation or Parole Officer?: ☐ Yes ☐No **If yes, name and number of Probation or Parole Officer:**	

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RECOVERY HOUSE REFERRAL FORM

BUREAU OF DRUG AND ALCOHOL SERVICES
CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I,______________________, do hereby consent to and authorize _____East End Cooperative Ministry__________
(Treatment Provider)

to release the following information as indicated below to:
_______________Health Choices/CCBH_______________.
Name of person/agency

____
Address/Telephone

The following information pertaining to myself. The information to be disclosed is:
___ Whether the Client is or is not in treatment
___ The nature of the project
___ Client progress
___ Whether or not the Client has relapsed
___ Prognosis
_X_ Other (specify)______To Determine ALDA eligibility.___

The information is needed for the following purpose:
___ Referral for treatment services
___ To monitor the provision of ongoing treatment
_X_ To obtain insurance, employment or government benefits
___ Other(specify)___________________________________

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42CFR, 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 the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

I may revoke this consent to release information at any time in writing or orally, except to the extent that action has been taken in reliance of it.

___ I have been offered a copy of this document and I have: ( ) Accepted ( ) Refused

___________________________________ ___________________________________
Signature of client / Date Signature of witness / Date

_____________________________Specify date upon which release will expire.

Release of information was revoked (Date and Time) _____________