Welcome to Maryland's RecoveryNet

Participant Application for Service

The attached Participant Application must be completed by you and your counselor. **It is important that you read each page carefully and understand the following:**

You will be receiving recovery support and/or clinical services funded through the federal Access to Recovery Program. The Maryland Alcohol and Drug Abuse Program manages these funds and services in Maryland. Your counselor will verify your eligibility for services. You must be at least 18 years old and meet the federal income standards for publically funded programs,and you must also be a Maryland resident and be planning to receive recovery support services in this State.

All participants agree to work with a Care Coordinator. Your Care Coordinator will assist you in accessing the services you have selected. They will set up a check-in telephone call every two weeks to discuss your recovery progress and assist you with identifying and accessing services or goods that support your recovery. In the application you are asked to identify information and individuals to assist your Care Coordinator in keeping in touch with you. Carefully give as much contact information as possible. Care Coordinator will not share confidential information. They may leave a message enabling you to contact them or ask if there is updated information on where you can be contacted.

Other Services which you may be entitled to and receive authorization include:

- **Halfway House (up to 45 Days)**
- **Recovery House (up to 60 days**
- **Transportation**
- **Employment Readiness**
- **Vital Document Services**
- **Gap Services**
- **Family/Couples Counseling**
- **Pastoral Counseling**

As recipient of RecoveryNet Services you agree to:

- **Complete three (3) Government Performance and Results Act Surveys (GPRA). SEE PAGE 3**
- **Bi-weekly contact with your Care Coordinator**
- **Use the vouchers I am given or work with my Care Coordinator to adjust my services**
- **Follow-through on referrals to recommended levels of care and/or other recovery support services**
- **Keep your Care Coordinator advised of any changes or problems with your authorized services**
- **Provide the requested contact information in the application so that we can keep in touch and assist you with recovery needs and administer the required GPRA**

STATE OF MARYLAND Department of Health and Mental Hygiene
Alcohol and Drug Abuse Administration
***Maryland RecoveryNet* : Access to Recovery Referral Form**

Application for Services : # ***Fax to Care Coordinator***

Applicant's Name: ____

Date:____________________ **Gender: M F**

Applicant Date of Birth: ___________________(mm/dd/yyyy)

Applicant SS#:_____________________ **SMART Client ID #**__________________________

Applicant Address: ____

Address City: __________________________________**State:** ____________**Zip:**____________

Phone #: (____) __________________**Cell Phone #: (____)** ________________

***RecoveryNet* Portal Program (Referring Program)**

Program Name:____

Counselor Name:____

Contact Information: (phone and/or email)__________________________________

Client Needs (please check all that apply)?

____Job Training	____Social Services/Benefits	____Food Assistance
____Employment	____Medical Services	____Childcare
____Educational Services	____Mental Health Services	____Tax Assistance
____Life Skills Services	____Energy Assistance	____Other:__________
____Housing/Rental Assistance	____Prescription Assistance	____Other:__________

At closure, please check all services the client has been connected to:

____Job Training	____Social Services/Benefits	____Food Assistance
____Employment	____Medical Services	____Childcare
____Educational Services	____Mental Health Services	____Tax Assistance
____Life Skills Services	____Energy Assistance	____Other:__________
____Housing/Rental Assistance	____Prescription Assistance	____Other:__________

Consent to Participate

I, ____, (Print Name) **agree to participate in the *RecoveryNet* program.**

Purpose: The purpose of this program is to increase access to treatment and recovery support services for persons with substance use disorders; and to provide clients with free and genuine choice of providers of treatment and recovery support services, to include faith based and community providers. The data collected as part of this program will help determine how helpful the *RecoveryNet* program is in enhancing recovery from substance use disorders.

Procedures: *RecoveryNet* program monitors may review my treatment or recovery support services records and my completed client satisfaction survey. From these records, monitors will collect information about the quality of services I received, progress I made, the length of time I received services, violations, and whether I finished the program or not.

Confidentiality: Information collected by each treatment or service provider will only be made available to program monitors and will not be made available to anyone else without my written permission, including probation/parole officials, family, or other treatment providers. Any information I give regarding past criminal behavior will be completely confidential. Disclosure of information about child sexual abuse, threat of harm to myself or others or information about any planned criminal activities cannot be kept confidential. The information collected for reporting to the Center for Substance Abuse Treatment (the agency that provides funding to support this program) will be collected as group data without information that can identify me. After five years, the data will be destroyed.

Risk: No risks are anticipated. My treatment and criminal justice status will not be affected by my answers. According to program policy, all participants and program monitors have been instructed to keep confidential all information obtained about me.

Benefits and Freedom to Withdraw: Although the data collected is not designed to help me personally, the information from this program will be used to help policymakers evaluating a method of delivering services to clients in similar situations. If I choose not to allow the monitors access to my information, I will be assessed for aftercare in the standard manner and will be eligible to receive services available outside the *RecoveryNet* program.

- In accepting RecoveryNet Services I agree to participate in three survey interviews.
  Government Performance and Results Act (GPRA) Survey is given at the following three (3) intervals:
  - Intake (Counselor)
  - Follow-up-Six months after intake (Care Coordinator)
  - Discharge from the *RecoveryNet* program. Can be given at Follow-up. (Care Coordinator)
- I will receive a $15 giftcard if I complete the six month follow-up interview

I understand that I am required to work with my Care Coordinator while receiving RecoveryNet Services and until I have completed my Follow-up and Discharge GPRA Surveys. I also understand that I am expected to follow-through with clinically recommended levels of care and/or community recovery support.

NOTE: In the event that my Care Coordinator cannot locate me in order to complete the GPRA

interview, I agree to allow him or her to contact the individuals listed on my contact page in order to confirm my whereabouts. The Care Coordinator will then contact me to conduct an interview with me. I understand that no confidential information will be provided to persons on the contact page unless I have authorized it through a consent document.

_______________________________ ___________
Signature of Participant **Date**

_______________________________ ___________
Signature of Witness/Monitor **Date**

Authorization for Disclosure of Last Known Address and Phone Number

The *RecoveryNet* program is funded through a federal grant that requires the State of Maryland Alcohol and Drug Abuse Administration (ADAA) to collect and report performance data to ensure the effectiveness and efficiency of the program. As a recipient of services through the *RecoveryNet* program you are requested to authorize the organizations indicated below to disclose your last known address and phone number(s) to ADAA and the *RecoveryNet* provider, so that you can be located in approximately 6 months for a follow up survey.

Name of Survey Participant (Print Name):_______________________________________

Date of Birth: _________________________ SS#: _________________________________

I authorize:

[ ] Maryland Department of Social Services/Maryland Department of Labor

[ ] Maryland Department of Public Safety and Correctional Services/Maryland Judicial System

[ ] Medical and/or Behavioral Health Treatment Center, Facility, Hospital or Clinic/Homeless Shelter or Outreach Agency

to **RELEASE** information regarding my last known address and phone number(s), to :

ADAA, 55 Wade Avenue, Catonsville, MD 21228

and ____ (the *RecoveryNet* provider) for the limited purpose of locating for a follow up survey. I further authorize ADAA and the *RecoveryNet* provider to **OBTAIN** my last known address and phone number(s) from the above indicated organizations for the limited purpose of locating me for the completion of a follow up survey.

Unless revoked by me, this consent shall expire on date below or in 12 months from date of application:

____

(Specific date, event or condition upon which this consent expires, only if different from above)

I understand that refusal to grant permission will in no way affect my right to obtain present and future treatment, except where disclosure of such communication and records is necessary for treatment. I understand that I may revoke this authorization at any time (not retroactively) by signing the "Cancellation/Revocation" section below, except to the extent that action has already been taken in reliance on it. **This authorization, if not revoked earlier by me, will expire on the date indicated above or in one year from the date of the signature below.**

I further understand that the confidentiality of psychiatric, drug and/or alcohol abuse and HIV records are protected under state and federal law and cannot be disclosed without my written authorization to disclose such information unless otherwise provided for by law.

I understand that I may make a request to inspect and/or copy the information obtained pursuant to this authorization. I further understand that ADAA or the *RecoveryNet* provider will provide me with a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law.

____

Survey Participant Signature **Date**

____

Witness Signature **Date**

CANCELLATION/REVOCATION

I understand that by signing below, I am revoking the authorization that I previously provided effective on the date of my signature. I understand that I must inform ADAA, and the *RecoveryNet* provider of my decision to revoke this authorization.

____

Survey Participant Signature **Date**

RecoveryNet Contact Sheet

Please read the following to the client: I agree to allow *RecoveryNet* # # and/or RecoveryNet staff to contact the individuals listed below to confirm my whereabouts. I understand that no confidential information will be provided to persons on the contact page unless I have authorized it through a separate consent to disclose information.

What is your name?

____

Last Name First Name Middle Name

Is this your married name? Yes No
(If yes, what is your maiden name?) ________________________________

What other name(s) are you known by? ________________________________

What is your mother's maiden name? ________________________________

What is your most recent address?

Address: ______________________________ Apt: __________

City: ______________________ State: ________ Zip: __________

Phone Number: ______________ Email: ______________________

Name and address of any other services/programs used recently: (shelter, community center, religious organization, health care clinic, soup kitchen/food pantry, case management, clinical treatment, veteran services, emergency room)

Program/Service Name: ________________________________

Contact Name: ________________________________

Address: ______________________________ Apt: __________

City: ______________________ State: ________ Zip: __________

Other Information: ________________________________

____

____

If something were to happen with your current living arrangements, where is the best place to find you in six months to complete the required GPRA six month follow-up?

PRIMARY CONTACT

Relatives, significant other, or someone we could contact that could assist us in contacting you:

Last Name: ______________________ First Name: ______________________

Address: ______________________________ Apt: ______________

City: ______________________ State: ________ Zip: __________

Relationship: ______________________________________

What is the phone number at this location? ______________________________

Email Address of this Contact: ______________________________

ADDITIONAL CONTACT PERSON

Do not repeat previously given contact

Last Name: ______________________ First Name: ______________________

Address: ______________________________ Apt: ______________

City: ______________________ State: ________ Zip: __________

What name is on the mailbox? (Does mail need to be in care of someone else?)

____

Whose place is it? Name: ______________________________

Relationship: ______________________________

What is the phone number at this location? ______________________________

Email Address of this Contact: ______________________________

ADDITIONAL CONTACT PERSON
Do not repeat previously given contact

Last Name: ______________________________ First Name: ________________________

Address: ____ Apt: __________________

City: ___________________________________ State: ___________ Zip: _____________

Relationship: ____

What is the phone number at this location? ___________________________________

Email Address of this Contact: ____

Additional Comments Regarding Contact Information:

____

____

____

____

____

Consent to Disclosure and Re-Disclosure of Confidential Information

I, (Print Name)____,

(Date of Birth) ______________, as a participant in the Maryland *RecoveryNet* program, understand my support services will be authorized through the *RecoveryNet* Coordinator in my region and the Administrative Services Organization designated by the State of Maryland to pay for the services I receive. I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing *RecoveryNet* program Requests:

1. *RecoveryNet* Regional Coordinator – Region ________________________________
2. Value Options Administrative Services Organization
3. Care Coordination Agency/Entity: ____
4. *RecoveryNet* Services I have chosen: Provider(s):
   ____
   ____
5. Outpatient Treatment Provider: ____
6. Other entities I would like to issue consent : (Include Name of organization/agency and type of service) ____

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, *RecoveryNet* support history and such other information as is necessary to provide effective coordination of the treatment and services I receive.
The Purpose of the disclosure authorized herein is to facilitate the provision of *RecoveryNet* program recovery supports.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I have received a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it.
Unless revoked by me, this consent shall expire upon date below or 12 months from application date:

(Specific date, event or condition upon which this consent expires, only if different from above)
____

____
Signature of Participant **Date**

o ....)

STATE OF MARYLAND Department of Health and Mental Hygiene
Alcohol and Drug Abuse Administration
Maryland RecoveryNet : Access to Recovery

Service Assessment/Needs Matching

Region: ________

Service Need	Assessment Information	Provider Name and Contact #	Date/Time Appointment
Care Coordination	**N/A (Required Service)**	**1.**	
Recovery Housing Assistance	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	
Halfway House	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	
Family /Marital Counseling	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	
Job Readiness Counseling	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	
Pastoral Counseling	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	
Childcare	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	
Transportation	o Bio-Pysch -Soc. o Client Interview o Explanation:	1. 2.	

Referral Choice Verification:

_____I have been shown a listing of ATR service providers and I enrolled with a provider of my choice.

_____The ATR service voucher creation and redemption process has been explained to me, and I understand the time-related limitations associated with redemption of the ATR vouchers that have been created for me.

____I understand that if I still have questions about my choice of service providers I may contact my Care Coordinator :_________________________________Phone________________

____

Participant (Signature) (Date)

____

Enroller (Signature) (Date)