RAPID ENGAGEMENT DELIVERY (RED) Program Referral

Please check all that apply

- ☐ Adult- 18 Years of age or older
- ☐ Resident of Monroe County
- ☐ Eligible for Temporary Assistance (TA) or presumed to be eligible (Does NOT receive SSI/SSD)
- ☐ History of unsuccessful attempts at obtaining Temporary Assistance (TA) benefits or currently unable to do so; OR history of emergency housing utilization

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Date of Referral: _____

First Name: _____ **Last Name:** _____ **DOB:** _____ **SSN:** _____

Do you require services in a language other than English? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Transgender

Race/Ethnicity: _____ **Marital Status:** _____

Client's Permanent or Temporary Address/Shelter

Street: _____

City: _____ **State:** _____ **Zipcode:** _____

Phone Number(s): _____

Referral Source: _____ **Agency:** _____ **Telephone #:**_____

Case Manager: _____ **Agency:** _____ **Telephone #:**_____

Mental Health Counselor: _____ **Agency:** _____ **Telephone #:**_____

Chemical Dependency Counselor: _____ **Agency:** _____ **Telephone #:**_____

Primary Care Physician: _____ **Agency:** _____ **Telephone #:**_____

Social Security Disability Status: _____ **Assisting Attorney:** _____ **Telephone #:**_____

Additional Comments:

Email referral to: REDTeam@monroecounty.gov

(ATTN: RED Program)

(Include both consents)

Version 4.0 – November, 2018

MONROE COUNTY DEPARTMENT OF HUMAN SERVICES
RAPID ENGAGEMENT DELIVERY (RED) PROGRAM

CONSENT TO USE AND DISCLOSE INFORMATION

CLIENT NAME: _____ _____ _____
Last First Middle

DATE OF BIRTH: _____ Last 4 digits of SS#: _____

I am interested in receiving services from the ***Monroe County RED Program***. In order to assess my eligibility for the program, I give permission to the organizations listed below to disclose information about my substance use and mental health treatment to the Monroe County Department of Human Services – Office of Mental Health, the Monroe County Single Point of Access (SPOA), the RED program, the Monroe County Recovery Connection Program, and Coordinated Care Services, Inc.

Liberty Resources
Monroe County Pre-Trial Services
Strong Memorial Hosp./University of Rochester
Helio Health
Catholic Family Center
Conifer Counseling
Mc Collaborative
Person Centered Housing Options
Evelyn Brandon Health Center
Rochester Regional Health System
Veteran's Outreach Center
Huther-Doyle
John L. Norris Clinic
Monroe County Treatment Courts

This information may include: my diagnosis, medical assessments, mental health evaluations, substance use evaluations, psychosocial assessments, results of lab work, recovery plans, discharge summaries, treatment recommendations, progress notes and billing information.
In addition, I understand that the Monroe County Care Coordination (RED) Program will release information to Coordinated Care Services, Inc. to use in evaluating the effectiveness of the program.

This permission expires when my referral to the RED program has been closed or I am no longer receiving services from this program.

I have read and understand the above permission statements, and I authorize the disclosure of the information described above. I understand that this consent may be withdrawn by me, with notice, at any time except to the extent that action has already been taken relying upon the consent. In all cases, this release shall expire when my referral to the Monroe County Care coordination services has been closed or I am no longer receiving services from this program. I understand that the disclosure is bound by Title 42 CFR Part 2 governing the confidentiality of client records and that redisclosure of this information to any party other than indicated in this consent is prohibited without additional written authorization by me. I have the right to cancel my authorization at any time before the information is released.

Client Signature: _____

Date: _____

I hereby cancel my authorization to release the information outlined on this form.

Client Signature: _____ Date: _____

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION REGARDING PERSONS WITH SUBSTANCE USE DISORDER

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS: **GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE (DISCLOSED/RELEASED) (CIRCLE)

Psychosocial/psychiatric/psychological/medical/vocational evaluations, lab results, level of care determination, progress in treatment, reasons for referral.

PURPOSE OR NEED FOR (DISCLOSURE/RELEASE) (CIRCLE)

To facilitate access to Substance Use Disorder services and to enhance continuity of care.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between:	And: **Monroe County Rapid Engagement Demonstration Team**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:_____

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____
(Signature of Patient)

_____
(Signature of Parent/Guardian, when required)

_____
(Print Name of Patient)

_____
(Print Name of Parent/Guardian)

_____
(Date)

_____
(Date)