

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 or currently have active TA)

_____ History of denials when applying for Temporary Assistance (TA) **OR** history of emergency housing utilization (combination of three or more in a 12-month period)

_____ Diagnosis of a Mental Health Disorder or Substance Use Disorder

Date of Referral: _____

Client Name: _____ **DOB:** _____

Full Social Security #: _____

Do you require services in a language other than English? _____ **YES** _____ **NO**

Gender: _____ **Male** _____ **Female** _____ **Transgender**

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

Dependents: _____ **YES** _____ **NO**

Client's Permanent or Temporary Address/ Shelter

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Care Manager Name: _____ **Agency:** _____

Care Manager Email: _____ **Phone #:** _____

Mental Health Counselor: _____ **Agency:** _____

Counselor Email: _____ **Phone #:** _____

Chemical Dependency Provider: _____ Agency: _____

CD Provider Email: _____ Phone #: _____

Primary Care Doctor: _____ Agency: _____

Doctor's Email: _____ Phone #: _____

Social Security Disability Status: _____

Assisting Attorney: _____ Attorney's Phone #: _____

Attorney's Email: _____

Any safety concerns? _____ YES _____ NO

If yes, please explain: _____

Referral Source: _____ Agency: _____

Referral Source Email: _____ Phone #: _____

**Please send completed referral and both attached consents
signed by client to:**

REDTeam@monroecounty.gov

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

**CONSENT FOR RELEASE OF INFORMATION
REGARDING PERSONS WITH SUBSTANCE USE
DISORDER**

REVOKED ON _____ Staff Sig _____

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

Between:

NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE
DISCLOSURE/RELEASE IS TO BE MADE

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 a party 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)