

Diversus Health Network - PO Box 15318, Colorado Springs, CO 80935 Phone number 719-572-6100 and fax number 719-572-6466

Email: HealthNetworkSUDReferrals@DiversusHealth.org

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Client Name: Client ID:

DOB: Effective:

**I do hereby consent and authorize Diversus Health to:**

Get information from and/or

Release private (confidential) information to the following person(s) and/or entity.

**□**

**□**

Name: All my treating providers at

Address:

City: State: Zip:

Phone Number: Fax Number:

**Information To Be Released**

## The information that can be obtained/disclosed under this authorization includes the following:

|  |  |  |
| --- | --- | --- |
| Assessments/Evaluations |  | Educational/Developmental |
|  |  |  |
| Person Centered Plans/Treatment Plans |  | Discharge/Transfer Recommendations |
|  |  |  |
| Progress Note |  | Information Related to Benefits or Insurance |
|  |  |  |
| Psychological Test/Reports |  | Work Related Information |
| Psychiatric Evaluations/Medication Reviews/Labs |  |  |
| Treatment/Service RecommendationsOther: |  |  |

**Transmission Modes**

**The information may be released in:**

 Written  Verbal  Electronic  Photo  Other:

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## Purpose of the Release:

 To provide comprehensive case coordination  To determine eligibility for services

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 At the request of the individual Other:

Assistance with Driver’s License

**□**

**□**

Diversus Health Services (rev 10/2019)



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| **Additional Information** |
| **Please note** – The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC). |
| **Alcohol/Drug Abuse:** |
|  I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse. |
| I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse. |
| **HIV/AIDS/Sexually Transmitted Disease/Communicable Disease** |
| I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease. |
| I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease. |

I understand that:

-The requested information may not be protected from re-disclosures by the parties it is released to and is no longer protected under federal privacy laws; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulation (42 CFR part 2), the party this is disclosed to may not re-disclose such information without my further written authorization provided for by state or federal law.

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* Substance Use Disorder related information can be released in the event of a bona-fide medical emergency without consent.
* Under 42 CFR Part 2, I have the right to request a list of disclosures to which disclosures have been made pursuant to the general designation
* For 42 CFR Part 2 violations, I can contact the US Attorney for Colorado at 1801 California Street, Suite 1600, Denver CO 80202, 1-303-454-0100
* Diversus Health has no control over this information after it is released and is not liable for any other disclosures.
* I may have a copy of this authorization.
* I may revoke this authorization at any time by notifying Diversus Health Medical Records in writing or by signing the revocation line of this form and returning it to Diversus Health Medical Records. Any revocation is for future releases and does not apply to any releases made prior to the revocation date.
* This authorization expires on or if left blank, two (2) years from my signature date.
* This authorization is not for the disclosure of psychotherapy notes, as Diversus Health does not maintain psychotherapy notes as part of the medical records.

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| Diversus Health Staff name: | Date: |

Client signature (12 years of age and over) Signature date

Client representative/Legal Guardian signature Signature date

Diversus Health Services (rev 10/2019)

**DIVERSUS HEALTH NETWORK**

# Additional Resources Request

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| **Date of request:** |
| **First Name** |
| **Last Name** |
| **Date of Birth** |
| **Phone Number** |
| **E-Mail** |
| **Please circle resources that you may need:****Mental Health Services Food Assistance ID/SSN Medication Assisted Treatment (MAT)****Medicaid/Medicare Transportation****Childcare****Sober Activities Legal Services** |
| **If you do not see resources that you need listed or need additional resources, please write them in this box.** |

**DIVERSUS HEALTH NETWORK**

# SOBER LIVING FUNDING REQUEST

E-mail Completed Sober Living Application and letter to: Soberlivingapp@diversushealth.org

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| **Your information: *All information must be entered to be considered for funding*** |
| **Name: Todays Date:** |
| **Date of Birth:** |
| **Phone:** |
| **Email:** |
| **Emergency Contact:** |
| **Emergency Contact Phone:** |
| **SOBER LIVING ARRANGEMENTS: *All questions must be answered to be considered for funding*** |
| **Where are you currently staying?** |
| **How much is rent contribution?** |
| **Do you owe a balance (circle one)? I do not owe a balance I do owe a balance Amount owed$**  |
| **Is this your first time in sober living (circle one)? This is my first time This is not my first time** |
| **If NO, what house(s) were you at?** |
| **What were your dates of stay (MM/YY)?** |
| **Have you been asked to leave a recovery residence (circle one)? I have been asked to leave I have not been asked to leave** |
| **If yes, why were you asked to leave?** |
| **RECOVERY*: All questions must be answered to be considered for funding*** |
| **What is your date of last use?** |
| **What is your drug of choice?** |
| **Other than sober living, what steps are you taking in your recovery?** |
| **What is your longest period of sobriety?** |
| **How were you able to maintain your sobriety during this period?** |
| **If coming from Detox, what made you decide to go to Detox**? |
| **INCOME/EMPLOYMENT: *All questions must be answered to be considered for funding*** |
| **Are you currently working? YES/NO** |

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| **If no, what steps are you taking to seek employment?** |
| **Do you receive disability benefits (SSI/SSDI/A&D)? YES/NO** |
| **If yes, how much do you receive a month?** |
| **Do you receive SNAP Benefits? YES/NO** |
| **Do you have a Valid ID? YES/NO** |
| **Do you have a Valid SSN YES/NO** |
| **Are you able to work, do chores and activities of daily living? YES/NO** |
| **RENT: *All questions must be answered to be considered for funding*** |
| **Have you received funding from Diversus Health in the pas**t? **YES/NO** |
| **If yes, provide date of previous funding:** |
| **How will you pay your rent and other bills if you are denied funding?** |
| **MEDICAL: *All questions must be answered to be considered for funding*** |
| **Do you currently have Medicaid or other Health Insurance (circle one)? No Insurance Medicaid Other** |
| **If other, provide name of other Health Insurance:** |
| **Do you have a Mental Health Diagnosis? YES/NO** |
| **If yes, provide diagnosis:** |
| **Are you prescribed any Medications for this diagnosis? YES/NO** |
| **If yes, list medications:** |
| **Do you take these medications as prescribed? YES/NO** |
| **Are you currently working with a therapist or psychiatrist? YES/NO** |
| **If yes, provide name and contact information:** |
| **If no, are you interested in receiving treatment? YES/NO** |
| **Do you have any health conditions? YES/NO** |
| **If yes, list health condition(s):** |

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| **Are you prescribed any medications for this condition? YES/NO** |
| **If yes, list medications:** |
| **Do you take these medications as prescribed? YES/NO** |
| **LEGAL: *All questions must be answered to be considered for funding*** |
| **Are you on Probation?** |
| **Are you on Parole?** |
| **If yes, provide name and contact information of Probation Officer:** |
| **Do you have any pending criminal charges?** |
| **Do you have any outstanding warrants?** |
| **If yes, please explain:** |
| **Do you have any upcoming court dates? YES/NO** |
| **If yes, provide dates:** |
| **Are you a sex offender? YES/NO** |
| **If yes, provide the date of the offense:** |
| **If yes, do you need to register? YES/NO** |

**First Month Funding Leter Requirements**

***All applications must include a letter that tells us you your personal story. Things that we would like to see in your letter would include your substance use history, traumatic events, and any recovery goals that you may have. We would like to know what support systems you have as well as any coping skills that you are currently using. Please be as detailed as possible.***

**\*Please note: Approval for funding does not guarantee placement into a specific home. All homes reserve the right to approve or deny potential residents at their discretion\***

**Additional Funding Letter Requirements**

**To be considered for any of funding you will need to write a NEW letter and complete a NEW application. This letter will need to tell us why you feel you need an additional month of funding, what progress you have made in your recovery since your last application, what has been working for you and where you feel you could use additional help. . These applications and letters MUST be sent through your house manager in order to be considered for additional funding.**

* **I support the request for additional funding. ☐I do not support the request for additional funding.**

**Comments:**

House Manager/Owner Signature Date