

DRUG AND ALCOHOL TREATMENT INFORMATION FORM

CASE IDENTIFICATION			
CO	DIST	RECORD #	DATE

NAME OF CLIENT:	LAST	FIRST	M.I.	SOCIAL SECURITY NUMBER
STREET NAME #	APT. #	CITY	STATE	ZIP CODE
				TELEPHONE NO. ()

TREATMENT CENTER NAME AND ADDRESS:

REFERRAL

This person is being referred for evaluation of a possible alcohol or drug abuse problem and possible entry into a treatment program. The clinic evaluation will assist the CAO in determining this person's eligibility for assistance. Please provide information below or on the reverse as requested. If necessary, copy for your records and return the original copy to the presenter, or mail to:

CAO ADDRESS: _____

IMCW NAME

I hereby authorize and request disclosure of information by my drug/alcohol treatment center to the County Assistance Office verifying that I am currently undergoing treatment for drug/alcohol abuse, the name and address of the drug/alcohol treatment program, the estimated length of the treatment, the type of treatment, whether the treatment program precludes me from any form of employment, and any related employability and treatment information requested on this form. I understand that the information obtained will be used only for purposes directly related to my eligibility for assistance for up to a lifetime limit of nine months. I also understand that this authorization can be revoked by me at any time except to the extent it has been acted upon, but will otherwise expire nine months after the date of my signature or on _____ if sooner than nine months.

APPLICANT/RECIPIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE

TITLE

62 P.S. §432(3)(i)(C) and (E) and 55 Pa. Code §141.61(d)(1)(v) require that, as a condition of eligibility for assistance, this person must keep any scheduled appointment and accept whatever approved treatment is prescribed for him/her if an evaluation substantiates that he/she has an alcohol or drug abuse problem, and his/her treatment program precludes any form of employment.

PROVIDER RESPONSE TO REFERRAL

SLOT AVAILABLE. START DATE _____ ESTIMATED LENGTH OF TREATMENT PERIOD _____

OUTPATIENT/INTENSIVE OUTPATIENT* PARTIAL HOSPITALIZATION RESIDENTIAL/HALFWAY HOUSE

TREATMENT SCHEDULE _____

DOES THE TREATMENT SCHEDULE PRECLUDE THE CLIENT FROM WORKING? YES NO

IF YES, WHY? _____ IF YES, WHEN WILL HE/SHE BE ABLE TO WORK? _____

*SCA SIGNOFF REQUIRED IF TREATMENT SCHEDULE REFLECTS 10 HOURS OR LESS PER WEEK BUT PRECLUDES EMPLOYMENT.

SLOT UNAVAILABLE. DATE FIRST SLOT AVAILABLE _____ CLIENT DID NOT KEEP APPOINTMENT.

