"You Are Predestined For A Purpose!"

Prince Georges County
State Care Coordination Referral Form

Please fax to **(301) 420-2384**

Date: _____ Referral Source: _____

Please complete all fields

Client Full Name: _____ Client Diagnostic Code: _____

DOB: _____ Social Sec #:_____ Gender (M/F) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Mobile Number: _____

Provider Services:

Provider Name: _____ LOC: _____

Contact Name: _____ Contact #: _____

Client Needs:

What needs has the client requested assistance for (please check all that apply)?

___Job Training	___Social Services/Benefits	___Food Assistance
___Employment	___Medical Services	___Educational Services
___Mental Health Services	___Transportation	___Anger Management
___Prescription Assistance	___Alcoholics/Narcotics Anonymous	

___Other_____

Updated: May 2021

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Release and Consent to Participate in Prince Georges County State Care Coordination Services

I, _____, (print full name)

understand that I have been referred to State Care Coordination Services Program.

Purpose: The purpose of this program is to increase access to recovery support services for persons with substance use disorders; and to provide clients with linkage and coordination of services as needed. As a recipient of residential and/or outpatient treatment services I am agreeing to cooperate in good faith and with diligence to enroll in State Care Coordination services.

Confidentiality: Information collected by the care coordinator agency will only be made available to program coordinators and will not be made available to anyone else without written permission. Disclosure of information about child sexual abuse, threat of harm to yourself or others or information about criminal activities will not be kept confidential and will be reported as mandated. The information collected for reporting to the Prince George's County Department of Health (the funding agency) will remain with the agency for five years.

Risk: No risks are anticipated. The treatment and criminal justice status will not be affected by my answers. All participants and care coordinator providers have been instructed to maintain confidentiality of all information obtained.

Benefits and Freedom to Withdraw: If I choose not to allow the care coordinators access to my information, I will have forfeited my option to have state care coordination services and will not be penalized.

□ I choose not to participate. Signature: _____ Date: _____

NOTE: In the event my Care Coordinator cannot locate me, I agree to allow him or her to contact the individuals listed as my contacts on the referral from in order to confirm my whereabouts. I understand that no confidential information will be provided to person(s) on the contact page unless I have given written authorization.

_____ _____

SIGNATURE OF PARTICIPANT **DATE**

_____ _____

SIGNATURE OF WITNESS/MONITOR **DATE**

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PRINCE GEORGE'S COUNTY STATE CARE COORDINATION PROGRAM APPLICATION

Client Name:	**Gender: M/F**	**Date of Referral:**
DOB:	**SS#:**	**Insurance Provider:**
Source of Income (TCA, SSI, TDAP, FS, etc.):		**Amount:**
Client Address :		**Contact #:**
City:	**State:**	**Zip Code:**
Client Contact Name:	**Relationship:**	
Telephone #:		**Contact #:**
Address:		
City:	**State:**	**Zip Code:**
Client Contact Name:	**Relationship:**	
Telephone #:		**Contact #:**
Address:		
City:	**State:**	**Zip Code:**

Client needs: (Please check all that apply)

___Job Training	**___Social Services/Benefits**	**___Food Assistance**
___Employment	**___Medical Services**	**___Educational Services**
___Mental Health Services	**___ Anger Management**	**___Transportation**
___Prescription Assistance	**___Alcoholics Anonymous**	**___Narcotics Anonymous**

___Other_____

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Destiny Power & Purpose, Inc.

Authorization for Release of Confidential Information about Alcohol or other Substance Use Treatment
Fax to (301) 420-2384

I, _____ (client name) authorize _____ (referring agency) and Destiny, Power & Purpose. Inc., which assist residents to obtain health care benefits and care, to communicate with and disclose to one another the following information:

1. My status as a patient in drug and/or alcohol treatment
2. Name
3. Social Security Number
4. Date of Birth
5. Medical insurance information as needed, to enable the agencies listed above to provide, coordinate and monitor my treatment for alcohol or other substance abuse, and primary health care

The purpose of these disclosures is to enable the agencies listed above to:

1. Provide support and follow up on the treatment I receive for alcohol and other substance abuse
2. Enroll me SCC services, additional recovery support services;
3. Provide referrals to available County, Faith-based and Community resources; and public assistance programs

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45CFR Pts. 160 & 164 and cannot be disclosed without my written consent at any time unless otherwise provided for in the regulations.

I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows: **one year from the date of this consent.**

I understand that I may be denied services if I reuse to consent to a disclosure for purposes of treatment, payment or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

_____ _____
Date Signature of Client

_____ _____
Date Witness

Prohibition on Re-disclosure of Information Concerning Client in Alcohol and /or Drug Abuse Treatment: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part . A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol abuse patients.

Patient Name: _____

Patient SS#: _____

Patient D.O.B. _____

Counselor Name: _____