Authorization for Release of Information

I, ___________________________ (Member's Name), residing at _____________________

_____________________(address) hereby authorize Nueva Luz to release and/or request information, as described below:

Person and/or Agency ____

Address ____

City _________________________________ State _________ Zip _____________________

Information provided will be used to ensure appropriate ongoing services. Information to be released includes the following:

Psychosocial Information

SMI Checklist

Ongoing Communications Regarding ISP

Current Treatment Plan (ISP)

Other

I understand that my records are protected under the Federal Privacy Regulations (42 CFR Part 2, 42 CFR Part 160 & 164) and cannot be disclosed without my written consent. I certify that this consent has been given freely and voluntarily. I understand that services are not contingent upon my consent for release of information. This consent may be revoked at any time by myself, except to the extent that action has already been taken on this consent. This consent will expire upon the event of my written request to terminate my relationship with Nueva Luz.

Member Signature ________________________________ Date __________________

Witness Signature ________________________________ Date ___________________

Nueva Luz Center Member Information Form – FY11

Name: ____________________________CPSA ID#_________________DOB: ___________

Street Address: ____ Zip: _____________

Home Phone: ___________________________ SS#________________________________

Case Manager: ____________________ Referral Agency: ___________________________

Site Location:____________________________ Site Phone: _______________________

AHCCCS ID#: _______________________ Plan Name: ___________________________

Primary Diagnosis Code (ICD-9):_____________TITLE XIX? YES ___ ___ NO _________

PERSONAL PHYSICIAN & PHONE:____

EMERGENCY CONTACT & PHONE: ____

ADDRESS: __________________________ RELATIONSHIP: _____________________

PHYSICAL OR MEDICAL LIMITATIONS:____

ALLERGIES: ____

MEDICATIONS & DOSAGES: ____

____

As a general rule, applicants should have six months of sobriety; however we will consider each application individually.

Is the applicant clean and sober? ____ For how long? _______

Has the applicant had any legal issues in the past year? ______

For what? _____________________________________

Member Signature: _________________________________ Date: __________

Witness Signature: ______________________________ Date: __________

Community Partnership of Southern Arizona
cpsa
Regional Behavioral Health Authority

Member Referral Packet Request

Name of CSA:	Hope, Inc.
Member Name:	
Name of Network:	
Name of Site Supervisor:	
Date Member Requested Service:	
Date of Referral Request:	
REFERRAL DUE DATE:	

We are a Title XIX Certified Community Service Agency in your area. A member who is enrolled with your agency recently requested support and rehabilitation services from our agency. According to the MI 5.2 Title XIX Certification Policy, all CSAs are now required to have a referral from the member's Network **PRIOR** to providing services. The enclosed is a referral packet request and referral checklist outlining all the documents that are now required by the Title XIX policy.

We are aware that it can sometimes take time to compile all the needed documentation, which may put the member at risk for not receiving the support and rehabilitation services that will benefit his/her recovery. It is an expectation that the referral process will be completed within two weeks from this date.

A timely and efficient method for obtaining the referral documentation is to have one of our agency's staff attend the next Adult Recovery Team/Child and Family Team meeting with this member and case manager. At this time, we can collect member information and assessment paperwork. We can also work collaboratively to fill out the ISP with the referral goal that best meets the member's treatment goals and is in keeping with our services and program description.

We are looking forward to working with this member on specific areas that will help him/her achieve his/her treatment and personal goals. Toward this end, we would like to offer any assistance in completing this referral process.

We appreciate your consideration and timely response in the coordination of care with this member.

Sincerely,
Michele Lynch
New Member Enrollment
HOPE,Inc.
Attention Site Supervisor: Please distribute these forms to the appropriate Network Staff for response to the CSA regarding this member.

CSA & Member Information

AGENCY NAME		MEMBER NAME	
AGENCY ADDRESS		MEMBER CIS NUMBER	
CITY/STATE/ZIP		MEMBER AHCCCS NUMBER	
AGENCY CONTACT		ROI EXPIRATION DATE	
AGENCY TELEPHONE		MEMBER ADDRESS	
AGENCY EMAIL		CITY/STATE/ZIP	
TODAY'S Date:		**PACKET DUE DATE:**	

THIS CSA PROVIDES THE FOLLOWING SERVICES (CHECK ALL THAT APPLY):

Support Services:		**Rehabilitation Services:**	
Respite	☐	Psycho educational Services	☐
Personal Care Services	☐	Ongoing Support to Maintain Employment	☐
Self Help/Peer Support	☐	Health Promotion	☐
Home Care Training Family	☐	Skills Training	☐
Transportation	☐	**Behavioral Health Day Programs:**	
		Supervised Day	☐

AGENCY PROGRAM DESCRIPTION:

PLEASE SUBMIT <u>ALL</u> DOCUMENTS LISTED ON THE *CSA REFERRAL PACKET CHECKLIST*

Box to be filled in only if CSA or Network declines referral:

Referral Declined ☐ **Reason declined**:

Signature of Staff: **Date:**

For Network use only:

Signature of Member: **Date:**

CSA Referral Packet Checklist

CSA Name	Hope, Inc.		
CSA Contact	Michele Lynch	Phone/ Fax Number	520-770-1197/520-622-3784
Network Name			
Network Contact		Phone/ Fax Number	
Member Name			
CIS Number		AHCCCS Number	

Documents Required by Policy:	Additional Documents Required by CSA:
☐ ***Complete*** **and current ISP with valid signature (within the last 12 months) with …** • **Specific treatment goal for referral to CSA** • **Date of current treatment plan** ☐ **Assessment or update (most current) with …** • **Diagnosis code/s and signature and licensed credentials of person authorized to diagnose** *If original assessment:* • ***ADHS/DBHS Behavioral Health Assessment & Service Plan Checklist and Part B Core Assessment, Clinical Formulation & Diagnoses*** *If update:* • ***Part E Annual Behavioral Health Update & Review Summary or Part D Behavioral Health Service Plan Review of Progress*** ☐ **Face sheet with current member information including emergency contact and Behavioral Health Eligibility Category (Title XIX, Non-Title XIX, etc.)** ☐ **Release of Information (date signed and expiration date)**	☐ **Third Party Liability** ☐ **Face Sheet indicating SMI Eligibility** ☐ **Other**

1200 N. Country Club RD.
Tucson, AZ 85716
520.770.1197
520.622.3784 FAX

RELEASE OF RESPONSIBILITY

I, ____________________________________, accept all responsibility when using the fitness area of HOPE/Nueva Luz and release HOPE, Inc. and its subsidiaries, the Board of Directors of HOPE, Inc. and all of their funding sources of any and all liability that may result in my use of the fitness area.

I understand and accept the implications of signing this Release of Responsibility and agree that I am signing this release voluntarily.

I understand and accept that if I choose not to sign this Release of Responsibility that I cannot utilize the Fitness Area.

Signature: ____

Date: ____

FAX COVER SHEET

TO: ______________________ FAX NUMBER: ______________________

FROM: ______________________ DATE: ______________________

SUBJECT: ______________________ TOTAL PAGES (INCLUDING COVER): ______________________

1200 N. Country Club • Tucson, AZ 85716 • 520.770.1197 • Fax 520.622.3784

Consent for Reproduction and Use of Name and Image for Marketing

NOTICE: Read and understand this form before signing. You are under no obligation to sign this consent and your refusal to sign will not affect your status as a member of HOPE, Inc. and the Nueva Luz Recovery Center.

I, voluntarily and without payment of any kind, consent to allow HOPE, Inc. to include my:

☐ name

☐ written story

☐ image (photograph)

in HOPE, Inc. newsletters or other marketing materials, which are available on our website and distributed in the community to promote programs.

I understand that my image and/or personal story will be (1) distributed in a newsletter that is subject to copying by members of the public and (2) posted on a web site that is subject to downloading and copying by members of the public and I acknowledge that HOPE, Inc. has no responsibility to protect my personal story from reproduction.

I understand that such use will result in other persons seeing my name and/or photograph, and the photograph may identify me as a member of HOPE, Inc.

I have read and understand this consent, and I sign it knowing that no royalty, fee or other payment of any kind shall be paid or become payable to me.

____

Signature Date

____

Print Name

Certification of Witness

I have discussed this consent with ___________________________________ and hereby certify that he or she understands the consent, and has signed freely and voluntarily in my presence.

____

Signature of Witness Date