STATE OF CONNECTICUT

BLOCK GRANT RECOVERY PROGRAM

Department of Mental Health & Addiction Services

Request Form for Recovery Support Resources

FAX TO: 860-967-0539

APPLICANT'S NAME: _____ EMS#: _____

INITIAL ELIGIBILITY REQUIREMENTS

- Clients admitted into any DMHAS private, not-for-profit substance use disorder agency.

APPLICANT INFORMATION

APPLICANT ADDRESS/LIVING SITUATION: _____

ADDRESS CONTINUED: _____

APPLICANT PHONE #: _____ APPLICANT SS#: _____

TREATMENT PROVIDER INFORMATION

NAME OF TREATMENT PROGRAM: _____

PROGRAM PHONE #: _____ PROGRAM FAX #: _____

DATE OF ADMISSION: _____ LEVEL OF CARE: _____

ANTICIPATED DATE OF DISCHARGE: _____

Based on the applicant's engagement/participation in treatment, would you advocate for the approval of BGRP Recovery Support Services? YES ☐ or NO ☐

TREATMENT PROVIDER STAFF NAME (please print): _____

TREATMENT PROVIDER'S SIGNATURE: _____

APPLICANT'S SIGNATURE: _____

DATE FORM COMPLETED: _____

Please note –original signatures are required and electronic signatures are not accepted.

REQUESTED RECOVERY SUPPORTS

Education or Training Course - *A current copy of registration or invoice/bill in the applicant's name is required.*
Education or Training Course: _____

Amount Requested: _____ Account Number: _____

Licenses or Certifications For Employment
Vendor Name and Address: _____

Amount Requested: _____

Tools For Employment
Vendor Name and Address: _____

Amount Requested: _____

Clothing For Employment
Vendor Name and Address: _____

Amount Requested: _____

OTHER – *Supporting documentation must be submitted along with the explanation of the request.*
Explanation of other items applicant may need and why: _____

_____

Vendor Name and Address: _____

Amount Requested: _____

Block Grant Recovery Program

APPLICANT STATEMENT

APPLICANT'S NAME: _____

Please describe how receiving these recovery supports will assist in your recovery. It is also important for you to tell us about your plans to become self-sufficient; update us about your job search or vocational training program; and/or tell us if you are working.

APPLICANT'S SIGNATURE: _____ DATE: _____

TREATMENT PROVIDER'S SIGNATURE: _____ DATE: _____

Please note –original signatures are required and electronic signatures are not accepted.

Department of Mental Health and Addiction Services (DMHAS)
Block Grant Recovery Program

Consent to Disclosure and Re-disclosure of Confidential Information and Records

I, _____, DOB: _____,
(Name of Participant) (Date of Birth)

EMS# _____, SS# _____ as a
(EMS Number) (Social Security Number)

participant in the DMHAS Block Grant Recovery Support Program, understand my treatment and support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing Block Grant Recovery Program requests:

1. The DMHAS Administrative Service Organization; and

2. _____
[Referring Treatment Provider/Program]

3. _____
[Requested Service Vendor(s)]

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, Block Grant Recovery Program history and such other information as is necessary to provide effective coordination of the treatment and services I receive.

The purpose of the disclosure authorized herein is to facilitate the provision of Block Grant Recovery Program services.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire upon completion of this application, or:

_____
[Specific date, event or condition upon which this consent expires, only if different from above]

Date:_____ _____
[Signature of Participant]

_____
[Signature of parent, guardian or authorized representative where required]

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 2. 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 or drug abuse patient.

Please note –original signatures are required and electronic signatures are not accepted.