**Maryland’s *RecoveryNet***

**Application for Service**

**April 2015**

The attached Participant Application must be completed by you and your counselor. It is important that you read each page carefully and understand the following:

You will be receiving recovery support and/or clinical services funded through the Maryland RecoveryNet initiative. The Behavioral Health Administration (BHA) manages these funds and services in Maryland. Your Counselor or Care Coordinator will verify your eligibility for services.

 In order to be eligible for Maryland RecoveryNet services, an individual must:

* Be 18 years of age or older
* Be a current resident of Maryland and planning to reside in Maryland for the duration of their work with MDRN
* Have a substance use disorder diagnosis
* Provide verification of income
* Have an income at or below 200% of the Federal Poverty Level ($22,340 for an individual or $30,260 for an individual with one dependent) and be without insurance or other financial resources to pay for MDRN services
* Be engaged in a clinical or recovery support service
* Request MDRN services

All participants agree to work with a Care Coordinator. Your Care Coordinator will assist you in accessing the services you have selected. They will set up a face-to-face appointment or check‐in telephone call every two weeks to discuss your recovery progress and assist you with identifying and accessing services or goods that support your recovery. In the application you are asked to identify information and individuals to assist your Care Coordinator in keeping in touch with you. Carefully give as much contact information as possible. Your Care Coordinator will not share confidential information. They may leave a message enabling you to contact them or ask if there is updated information on where you can be contacted.

**Services you may be entitled to and receive authorization include:**

* Halfway House
* Recovery House
* Transportation
* Employment Services (Speak with the RAC for availability)
* Vital Document Services
* Gap Services
* Peer Support/Recovery Coaching

**Maryland *RecoveryNet*: Application for services**

**Application for Services**

Date: Are you a Drug Court client? \_\_\_Yes \_\_\_No

Name:

Gender: Male Female \_\_\_\_\_Transgendered

Date of Birth: (mm/dd/yyyy)

SS#: MA#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ValueOptions M-Number#: \_\_\_\_\_\_\_\_\_\_\_ (if applicable)

Address:

City: State: Zip:

Phone: Cell Phone:

**As recipient of Maryland *RecoveryNet* Services I agree to:**

* Complete the intake interview, follow-up questionnaire, and Client Satisfaction Survey.
* Bi‐weekly contact with my Care Coordinator
* Follow‐through on referrals to recommended levels of care and/or other recovery support services provided by my Care Coordinator
* Keep my Care Coordinator advised of any changes or problems with my authorized services
* Provide the requested contact information in the application and update my contact information if/when it changes

I understand that all services are subject to fund availability

Applicant’s Signature Date

***Maryland RecoveryNet* Referring Program Contact Information**

Program Name:

Counselor Name:

Phone: Email:

**Maryland *RecoveryNet*: Application for services**

***Consent to Participate***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Print Name) **agree to participate in the *Maryland* *RecoveryNet* program.**

**Purpose:** The purpose of this program is to increase access to treatment and recovery support services for persons with substance use disorders; and to provide clients with free and genuine choice of providers of treatment and recovery support services, to include faith based and community providers. The data collected as part of this program will help determine how helpful the *Maryland RecoveryNet* program is in enhancing recovery from substance use disorders.

**Procedures:** *Maryland RecoveryNet* program monitors may review my treatment or recovery support services records and my completed satisfaction survey. From these records, monitors will collect information about the quality of services I received, progress I made, the length of time I received services, violations, and whether I finished the program or not.

**Confidentiality:** Information collected by each treatment or service provider will only be made available to program monitors and will not be made available to anyone else without my written permission, including probation/parole officials, family, or other treatment providers. The information collected for reporting to the Behavioral Health Administration (the agency that provides funding to support this program) will be collected as group data without information that can identify me. After five years, the data will be destroyed.

**Risk:** No risks are anticipated. My treatment and criminal justice status will not be affected by my answers. According to program policy, all participants and program monitors have been instructed to keep confidential all information obtained about me.

**Benefits and Freedom to Withdraw:** Although the data collected is not designed to help me personally, the information from this program will be used to help policymakers evaluate a method of delivering services to clients in similar situations. If I choose not to allow the monitors access to my information, I will be assessed for aftercare in the standard manner and will be eligible to receive services available outside the *Maryland RecoveryNet* program.

In accepting *RecoveryNet* Services, I agree to participate in three survey interviews:

* Intake interview (Care Coordinator)
* Follow-Up six months after intake (Care Coordinator)
* Discharge from the *Maryland RecoveryNet* program, which can be completed at the Follow-Up (Care Coordinator)

I will receive a $20 gift card, if I complete the six month Follow-Up survey (must be completed 6 months after the Intake).

**Maryland *RecoveryNet*: Application for services**

I understand that I am required to work with my Care Coordinator while receiving *Maryland RecoveryNet* Services and until I have completed my Follow-Up, Discharge, and Satisfaction Surveys. I also understand that I am expected to follow-through with clinically recommended levels of care and/or community recovery support.

My Basic Rights as a MDRN Service Recipients, Responsibilities and the Recipient Grievance Process were explained to me, and I have been given a copy for my records. I understand that I have a right to submit a grievance without fear of penalty or loss of services.

**NOTE:** In the event that my Care Coordinator cannot locate me in order to complete the Follow-Up interview, I agree to allow him or her to contact the individuals listed on my contact page in order to confirm my location. The Care Coordinator will then contact me to conduct the Follow-Up interview with me. I understand that no confidential information will be provided to persons on the contact page unless I have authorized it through a consent document.

Applicant Signature Date

Witness/Monitor Signature Date

**Referral Choice Verification:**

 I have been show a listing of Maryland RecoveryNet service providers and I enrolled with a provider of my choice.

\_\_\_\_\_\_ The MDRN service voucher creation and redemption process has been explained to me, and I understand the time-related limitations associated with redemption of the MDRN vouchers that have been created for me.

 I understand that if I still have questions about my choice of service providers, I may contact my

Care Coordinator : Phone:

 Participant (Signature) (Date)

Care Coordinator (Signature) (Date)

**Maryland *RecoveryNet*: Application for services**

**Authorization for Disclosure of Last Known Address and Phone Number**

The Maryland *RecoveryNet* (MDRN) program is funded through a state grant that requires the State of Maryland Behavioral Health Administration to collect and report performance data to ensure the effectiveness and efficiency of the program. As a recipient of services through the MDRN program, you are requested to authorize the organization indicated below to disclose your last known address and phone numbers(s) to BHA and the *RecoveryNet* provider, so that you can be located in approximately six months for the Follow-Up Survey.

Service Recipient Name: Please Print

Date of Birth: (mm/dd/yyyy) SS#:

I authorize (check all that are applicable)

\_\_\_**Maryland Department of Public Safety and correctional Services/Maryland**

**\_\_\_DSS**

**\_\_\_Criminal Justice System/Parole & Probation Agents**

**\_\_\_Certified Peer Recovery Specialist**

**\_\_\_Other please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

to release information to the Care Coordination agency for Maryland RecoveryNet and/or the Behavioral Health Administration regarding my last known address and phone number(s).

Unless revoked by me, this consent shall expire on the date below or in 12 months from the date of this application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(specific date, event or condition upon which this consent expires, only if different from above)

I understand that refusal to grant permission will in no way affect my right to obtain present and future treatment, except where disclosure of such communication and records is necessary for treatment. I understand that I may revoke this authorization at any time (not retroactively) by signing the “Cancellation/Revocation” section below, except to the extent that action has already been taken in reliance on it.

**This authorization, if not revoked earlier by me, will expire on the date indicated above or in one year from the date of the signature below.**

I further understand that the confidentiality of psychiatric, drug and/or alcohol abuse and HIV records are protected under state and federal law and cannot be disclosed without my written authorization to disclose such information unless otherwise provided for by law. I understand that I may make a request to inspect and/or copy the information obtained pursuant to this authorization. I further understand that BHA or the *RecoveryNet* provider will provide me with a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re‐disclosure by the recipient and no longer protected by Federal law.

Service Recipient Signature Date

Witness/Monitor Signature Date

**CANCELLATION/REVOCATION**

I understand that by signing below, I am revoking the authorization that I previously provided effective on the date of my signature. I understand that I must inform BHA, and the *RecoveryNet* provider of my decision to revoke this authorization.

Service Recipient Signature Date

**Maryland *RecoveryNet*: Application for services**

 **AUTHORIZATION TO DISCLOSE SUBSTANCE USE TREATMENT INFORMATION FOR COORDINATION OF CARE**

**Name of Patient** **DOB**: **Address: Phone Number: Medical Assistance Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1: Purpose of Authorization**

This Authorization to disclose is for the purpose of permitting the Maryland Medical Assistance Program (the Medicaid program), my substance use treatment provider, and any other providers identified in this form to coordinate my care so that it is more beneficial to me. By giving my consent, my Medicaid Managed Care Organization and any other providers specifically identified on this form will have access to information about substance use treatment I am receiving, which will help avoid conflicts in medication or treatment and improve the care I am receiving. By giving this consent, I may also gain access to other case management services offered through the Medicaid program.

**Section 2: Name** [Name of Provider]

Address:

**Section 3: Duration and Revocation of Authorization**

I may revoke this Authorization at any time either verbally or in writing by informing my substance use treatment provider of my wish to revoke authorization. I may also revoke this authorization by writing to the Maryland Medicaid Program’s administrative services organization, ValueOptions Maryland, at:

ValueOptions, Inc. EDI Helpdesk / PO Box 1287, Latham, NY 12110 Phone: 800.888.1965 Fax: 877.502.1044

# This Authorization’s effective date is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_. **This Authorization expires when (1) I revoke the Authorization; (2) I am no longer enrolled in a Medicaid Managed Care Organization; or (3) I am no longer receiving treatment from a substance use treatment provider.**

**Section 4: Authorization**

**I hereby authorize** my substance use treatment provider to disclose to the Maryland Medicaid Program (including its administrative services organization, ValueOptions Maryland), claims and authorization data resulting from my treatment, for purposes of coordination of my care. I also authorize the Maryland Medicaid Program (including ValueOptions Maryland), to re-disclose my claims and authorization data to the Medicaid Managed Care Organization in which I am enrolled, and with any additional health care providers listed on this form below, for purposes of coordinating my health care. I further authorize my substance use treatment provider to disclose medical records requested by my MCO’s patient care coordination team, for purposes of coordinating my care.

I understand that the information that may be disclosed as a result of this authorization may not be re- disclosed to any entity other than those entities identified in this authorization.

I have been provided a copy of this Authorization.

Patient Signature Date

Parent or Guardian Signature\* (if applicable) Date

#  Additional health care provider(s) with whom information about my care may be shared:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* NOTE: If you are signing as the member’s Legally Authorized Representative, attach a copy of the legal document(s) granting you the authority to do so. Examples are a health care power of attorney, a court order, guardianship papers, etc.

The following are the Maryland Medicaid Managed Care Organizations (MCOs):

# **Amerigroup Community Care** **MedStar Family Choice**

Compliance Officer Compliance Officer

7550 Teague Road, Ste 500 8094 Sandpiper Circle, Ste O

Hanover, Maryland 21076 Baltimore, MD 21236

410-859-5800 410-933-3014

**Jai Medical Systems Priority Partners**

Compliance Officer Baymeadow Industrial Park

5010 York Road 6704 Curtis Court

Baltimore, MD 21212 Glen Burnie, MD 21060

410-433-2200 410 424-4400

# **Kaiser Permanente Riverside Health of Maryland**

Compliance Officer Compliance Officer

2101 East Jefferson Street 1966 Greenspring Dr., 6th Floor

Rockville, MD 20852 Timonium, MD 21093

301-816-2424 410-878-7709

# **Maryland Physicians Care** **United Healthcare**

Compliance Officer Compliance Officer

509 Progress Drive Lyndwood Executive Center

Linthicum, MD 21090-2256 Elkridge, MD 21075

800-953-8854 410-379-3457

**Maryland *RecoveryNet*: Application for services**

***Maryland RecoveryNet* Collateral Contact Sheet**

My signature below signifies my agreement to allow the Care Coordinator and/or *Maryland RecoveryNet* staff to use the information below to locate me. I understand that no confidential information will be posted in a public space or provided to persons on the contact page unless I have authorized it through a separate consent to disclose information to that person or provider.

Service Recipient Signature Date

Last name First Name Middle Name

Is this your married name? Yes No

If yes, what is your maiden name?

What other names are you known by?

What is your most recent address?

Address:

City: State: Zip:

Phone: Cell Phone:

Email:

Social Media Contact: (Facebook, Twitter, Linkedin, My Space, etc.)

* I consent to be contacted via email or social networking sites. Initials:

Name and address of any other services/programs used recently: (shelter, community center, religious organization health care clinic, soup kitchen/food pantry, case management, clinical treatment, veteran services, emergency room)

Program/Service Name:

Contact Name:

Address:

City: State: Zip:

Other Information:

* I consent to be visited at the facility (ies) listed above. Initials:

**Maryland *RecoveryNet*: Application for services**

If something were to happen with your current living arrangements, where is the best place to find you in six months to complete the required four-six-month Follow-Up interview?

**PRIMARY CONTACT**

Spouse, relatives, significant other, or someone we could contact that could assist us in contacting you:

Last Name: First Name:

Address:

City: State: Zip:

Phone: Cell Phone:

Email:

Relationship:

* You may contact this person or visit this home. Client Initials:

**ADDITIONAL CONTACT PERSON**

Do not repeat previously given contact:

Last Name: First Name:

Address:

City: State: Zip:

Phone: Cell Phone:

Email:

Relationship:

* You may contact this person or visit this home. Client Initials:

**ADDITIONAL CONTACT PERSON**

Do not repeat previously given contact:

Last Name: First Name:

Address:

City: State: Zip:

Phone: Cell Phone:

Email:

Relationship:

* You may contact this person or visit this home. Client Initials:

**Maryland *RecoveryNet*: Application for services**

**Consent to Disclose and Re-Disclosure of Confidential Information**

I, (Print Name) Date of Birth: , as a participant in the Maryland *RecoveryNet* program, understand my support services will be authorized through the Maryland *RecoveryNet* Care Coordinator in my region and the Administrative Services Organization designated by the State of Maryland to pay for the services I receive. I authorize the BHA, Value Options and my MDRN Care Coordination provider (please list) to release and exchange information with the following agency/provider for the purpose of processing Maryland *RecoveryNet* program requests:

Provider:

Address:

Phone #:

This information may include: my name, address, age, gender, social security number, clinical assessment, Maryland *RecoveryNet* support 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 Maryland *RecoveryNet* program recovery supports.

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 cannot be disclosed without my written consent unless otherwise provided for in the regulation. I have received 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 the date below or 12 months from the application date:

(specific date, event or condition upon which this consent expires, only if different from above)

Service Recipient’s Signature Date

Witness/Monitor Signature Date

**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 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 abuse patients.

**Maryland *RecoveryNet*: Application for services**

**Maryland RecoveryNet**

**Service Recipient Basic Rights and Responsibilities**

**&**

**Grievance Process**

**Service Recipient Rights**

All Maryland RecoveryNet staff, Care Coordination and Recovery Support Service Providers have a responsibility to treat clients humanely, fairly, and with full respect for civil liberties and basic rights including, but not limited to, the following:

1. The right to appropriate and considerate care and protection.
2. The right to recognition and consideration of cultural and spiritual values.
3. The right to be informed about available MDRN covered services and to choose a provider.
4. The right to refuse a recommended service or plan of care.
5. The right to review records and information about your services.
6. The right to confidentiality regarding communications and records.
7. The right to be treated without discrimination on the basis of race, color, sex/sexual orientation, or national origin.

**Service Recipient Responsibilities**

1. Complete the intake, follow-up interview and Satisfaction Survey.

2. Bi‐weekly contact with your Care Coordinator

3. Follow‐through on referrals to recommended levels of care and/or other recovery support services.

4. Keep your Care Coordinator advised of any changes or problems with your authorized services.

5. Provide the requested contact information in the application

**Service Recipient Grievance Process**

A recipient of Maryland *RecoveryNet* services has a right to submit a grievance without fear of penalty or loss of services. Should a recipient have a grievance regarding services received via the Maryland *RecoveryNet* program, all efforts shall be made to resolve the grievance via the provider agency’s grievance procedure. If the grievance cannot be resolved at the provider level, then the recipient is encouraged to call their Care Coordinator and/or Maryland *RecoveryNet* Regional Area Coordinator (RAC). All complaints received by the Maryland *RecoveryNet* RAC will be documented and investigated. The Behavioral Health Administration (BHA) will be informed of all documented grievances, investigation results, and grievance resolutions. **Complaints may also be filed by email at** patricia.konyeaso@maryland.gov, or in writing to

Behavioral Health Administration, Attention: Patricia Konyeaso, Vocational Rehabilitation Building, 55 Wade Ave Catonsville, MD 21228.

**Care Coordinator** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_

**COPY FOR APPLICANT**