

**Welcome to Maryland's *RecoveryNet***  
**ATR Client Application for Service**  
**April 2014**

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 federal Access to Recovery Program. The Maryland Alcohol and Drug Abuse Program manages these funds and services in Maryland. Your counselor will verify your eligibility for services. You must be at least 18 years old and meet the federal income standards for publically funded programs, and you must also be a Maryland resident and be planning to receive recovery support services in this State.

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 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.

**Other services which you may be entitled to and receive authorization include:**

- Halfway House (up to 45 Days)
- Recovery House (up to 60 days)
- Transportation
- Employment Readiness
- Vital Document Services
- Gap Services
- Family/Couples Counseling(until 12/31/13)
- Pastoral Counseling(until 12/31/13)

**As recipient of *RecoveryNet* Services you agree to:**

- Complete three (3) Government Performance and Results Act Surveys (GPRA). SEE PAGE 3
- Bi-weekly contact with your Care Coordinator
- Use the vouchers I am given or work with my Care Coordinator to adjust my services
- Follow-through on referrals to recommended levels of care and/or other recovery support services
- Keep your Care Coordinator advised of any changes or problems with your authorized services
- Provide the requested contact information in the application so that we can keep in touch and assist you with recovery needs and administer the required GPRA

State of Maryland Department of Health and Mental Hygiene  
Alcohol and Drug Abuse Administration  
Maryland RecoveryNet: Access to Recovery Client Application

**Client Application for Services**

Date: \_\_\_\_\_

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

Gender Identity: \_\_M \_\_F \_\_Transgender Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

SS#: \_\_\_\_\_ SMART Client ID#: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Have you completed a GPRA for ATR services in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RecoveryNet Referring Program**

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

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

**Counselor Contact Information**

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## ***Consent to Participate***

I, \_\_\_\_\_, (Print Name) **agree to participate in the *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 *RecoveryNet* program is in enhancing recovery from substance use disorders.

**Procedures:** *RecoveryNet* program monitors may review my treatment or recovery support services records and my completed client 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. Any information I give regarding past criminal behavior will be completely confidential. **Disclosure of information about child sexual abuse, threat of harm to myself or others or information about any planned criminal activities cannot be kept confidential.** The information collected for reporting to the Center for Substance Abuse Treatment (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 evaluating 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 *RecoveryNet* program.

In accepting *RecoveryNet* Services, I agree to participate in three survey interviews. Government Performance and Results Act (GPRA) Survey is given at the following three intervals:

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

I will receive a \$15 giftcard, if I complete the six month Follow-Up survey (must be completed within 5-8 months of the Intake).

I understand that I am required to work with my Care Coordinator while receiving *RecoverNet* Services and until I have completed my Follow-Up, Discharge GPRA, and Client 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 Client Rights, 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 GPRA 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.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Monitor Signature

\_\_\_\_\_  
Date

**Referral Choice Verification:**

\_\_\_\_\_ I have been show a listing of ATR service providers and I enrolled with a provider of my choice.

\_\_\_\_\_ The ATR service voucher creation and redemption process has been explained to me, and I understand the time-related limitations associated with redemption of the ATR 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)

\_\_\_\_\_  
Enrollee (Signature) (Date)

**Authorization for Disclosure of Last Known Address and Phone Number  
Department of Public Safety and Correctional Services**

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

Client Name: Please Print \_\_\_\_\_

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

I authorize the ADAA and the **Maryland Department of Public Safety and correctional Services/Maryland**

**Judicial System** to release information to my ATR Provider \_\_\_\_\_ 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 ADAA 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.

\_\_\_\_\_  
Client 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 ADAA, and the *RecoveryNet* provider of my decision to revoke this authorization.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**Authorization for Disclosure of Last Known Address and Phone Number  
Department of Social Services**

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

Client Name: Please Print \_\_\_\_\_

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

I authorize the Maryland Alcohol and Drug Abuse Administration and the **Maryland Department of Social Services** to release information to my ATR Provider \_\_\_\_\_ 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 ADAA 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.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Monitor Signature

\_\_\_\_\_  
Date

**CANCELLATION/REVOCAION**

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 ADAA, and the *RecoveryNet* provider of my decision to revoke this authorization.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

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

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

Client Name: Please Print \_\_\_\_\_

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

I authorize the ADAA and (other provider agency) \_\_\_\_\_ to release information to my ATR Provider \_\_\_\_\_ 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: \_\_\_\_\_  
(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 ADAA 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.

\_\_\_\_\_  
Client 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 ADAA, and the *RecoveryNet* provider of my decision to revoke this authorization.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date



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 six-month Follow-Up GPRA Survey?

**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: \_\_\_\_\_

### 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 *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 ADAA, ValueOptions and my ATR Care Coordination provider (please list) \_\_\_\_\_ to release and exchange information with the following agency/provider for the purpose of processing *RecoveryNet* program requests:

Provider: \_\_\_\_\_

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

Phone #: \_\_\_\_\_

This information may include: my name, address, age, gender, social security number, clinical assessment, *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 *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)

\_\_\_\_\_  
Client 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**  
**Basic Client Rights and Client Responsibilities**  
**&**  
**Recipient Grievance Process**

**Client Rights**

All MD RecoveryNet/ATR 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 client 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 ATR 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.

**Client Responsibilities**

1. Complete three (3) Government Performance and Results Act Surveys (GPRA).
2. Bi-weekly contact with your Care Coordinator
3. Use the vouchers I am given or work with my Care Coordinator to adjust my services.
4. Follow-through on referrals to recommended levels of care and/or other recovery support services.
5. Keep your Care Coordinator advised of any changes or problems with your authorized services.
6. Provide the requested contact information in the application so that we can keep in touch and assist you with recovery needs and administer the required GPRA

**Recipient Grievance Process**

Recipient grievances are defined as a complaint against a *RecoveryNet* service provider. A recipient of *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 *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 *RecoveryNet* Regional Area Coordinator (RAC). All complaints received by the *RecoveryNet* RAC will be documented and investigated. The Alcohol & Drug Abuse Administration (ADAA) will be informed of all documented grievances, investigation results, and grievance resolutions.

Complaints may also be filed with the Project Director for Maryland RecoveryNet by phone at 410 402-8620, by email at [deirdre.davis@maryland.gov](mailto:deirdre.davis@maryland.gov), or in writing to Alcohol and Drug Abuse Administration Attention: Deirdre Davis, 55 Wade Ave Catonsville, MD 21228.

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

**CLIENT COPY**

