

**Maryland
Department of Health and
Mental Hygiene**

**Behavioral Health Administration
Maryland RecoveryNet
FORMS
AND
OTHER DOCUMENTATION
SUPPLEMENT TO THE
MARYLAND RECOVERYNET
PROVIDER MANUAL
CARE COORDINATORS**

April 2015

*BHA/Maryland RecoveryNet reserves the right to
make changes to the Supplement and Provider Manual as needed.*

Table of Contents
Maryland RecoveryNet
Service Recipient Enrollment Form
Service Provider Fee Schedule
Application for Services
Repayment Invoice
Critical Incident Report
Summary: Privacy Rule HIPAA
Receipt of Services
Satisfaction Survey
Housing Intake Form
VO Guide for Claims Submission
VO Provider Alerts

Maryland RecoveryNet Service Recipient Enrollment Form

Date:

Care Coordinator Name/Agency:

Re: Maryland RecoveryNet Eligible Participant

I have a Maryland RecoveryNet eligible participant

First Name _____

Last Name _____

D.O.B _____

Social Security # _____

They are requesting the following services:

- Care Coordination Monthly transportation card
- Vital Docs Birth certificate MD ID
- Halfway Housing Recovery Housing Employment services
- Peer Support services GAP Transitional \$ _____ GAP Clothing \$ _____
- GAP Support services \$ _____ GAP Medical \$ _____

Verification is on file that the applicant is 200% below poverty

Does the applicant have insurance? No Yes:

MA# _____

Is a W-9 required for any of the requested services? _____

Is the applicant enrolled in SCC? If yes, where _____

The applicant was referred from (identify agency) _____

The applicants attends outpatient treatment or recovery services at _____

What is the applicants plan for housing after 30 days? _____

Where does the service recipient currently reside? _____

Applicants' legal/criminal history _____

**Maryland RecoveryNet
Service Provider Fee Schedule
3/1/2015**

| MDRN Fee Schedule for Effective 3-1-15 | | | | | |
|-----------------------------------------------|-----------------------------------------------------|---------------------|----------------------------|------------------------------------------|------------------------------------------------------------------------------------|
| CPT Code | Service Description | Billing Unit | Rate | Max Daily Unit/ Service Limit | Place of Service |
| MDRN1 | Half -Way House (clinical) | Daily | \$60.00 | 30 day max* | 55, 99 |
| MDRN2 | Recovery/Supported Housing | Daily | \$25.00 | 30 day max* | 14, 99 |
| MDRN3 | MDRN Intake interview | Unit | \$100.00 | 1 Unit | 57, 99 |
| MDRN4 | Care Coordination Check-ins | Unit | \$15.00 | 24 Units | 57, 99 |
| MDRN5 | Transportation | | individualized by provider | | 99 |
| MDRN6 | Vital Documents | Unit (2 documents) | \$50.00 | 2 Units | 57, 99 |
| MDRN7 | Gap Services-Transitional Services | Unit | \$1.00 | 50 Units | 57, 99 |
| MDRN8 | Gap Service- clothing | Unit | \$1.00 | 50 Units | 57, 99 |
| MDRN9 | Gap Services-Support Services | Unit | \$1.00 | 150 Units | 57, 99 |
| MDRN0 | Gap Services-Medical | Unit | \$1.00 | 250 Units* | 57, 99 |
| MDR11 | Peer Support Intake Interview | Unit | \$75.00 | 1 Unit | 11, 55, 57,99 |
| MDR12 | Peer Support Encounter | Unit=15 min. | \$12.00 | 16 units /mth max | 11, 55, 57,99 |
| MDR13 | Peer Support Leisure Activity | Unit | \$25.00 | 4 Units | 55, 57, 99 |
| MDR14 | Peer Support Recovery Call | Unit | \$5.00 | 5 Units/mth max | 11, 99 |
| MDR15 | Follow-up Questionnaire Gift Card | Unit | \$20.00 | 1 Unit | 11, 55, 57, 99 |
| MDR16 | Six month follow-up survey/MDRN satisfaction survey | Unit | \$130.00 | 1 Unit | 11, 55, 57, 99 |
| | Maximum payment per consumer = \$4,500.00 | | | | * -- additional services must be authorized by the Regional Area Coordinator (RAC) |

**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 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 Survey. 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.

Applicants' 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.

Applicants' 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

Maryland RecoveryNet: Application for services

Maryland RecoveryNet: Application for services

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

Compliance Officer
7550 Teague Road, Ste 500
Hanover, Maryland 21076
410-859-5800

MedStar Family Choice

Compliance Officer
8094 Sandpiper Circle, Ste O
Baltimore, MD 21236
410-933-3014

Jai Medical Systems

Compliance Officer
5010 York Road
Baltimore, MD 21212
410-433-2200

Priority Partners

Baymeadow Industrial Park
6704 Curtis Court
Glen Burnie, MD 21060
410 424-4400

Kaiser Permanente

Compliance Officer
2101 East Jefferson Street
Rockville, MD 20852
301-816-2424

Riverside Health of Maryland

Compliance Officer
1966 Greenspring Dr., 6th Floor
Timonium, MD 21093
410-878-7709

Maryland Physicians Care

Compliance Officer
509 Progress Drive
Linthicum, MD 21090-2256
800-953-8854

United Healthcare

Compliance Officer
Lyndwood Executive Center
Elkridge, MD 21075
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
&
Recipient 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



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Behavioral Health Administration • Spring Grove Hospital Center
• Voc Rehab Building 55 Wade Avenue • Catonsville, Maryland 21228
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary
Gayle Jordan-Randolph, M.D., Deputy Secretary - Brian M. Hepburn, M.D., Executive Director

Maryland RecoveryNet Repayment Invoice (3/2015)

Provider Name: _____ Contact: _____

Location: _____

The above listed provider is required to repay the Department of Health and Mental Hygiene for Maryland RecoveryNet-services that were not delivered or were incorrectly billed.

| M-Number # | Service Type | Date(s) of Service for repayment | Amount per unit | Total Amount for repayment |
|------------|--------------|----------------------------------|-----------------|----------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Total amount for repayment: \$ _____

Please make the check payable to: DHMH
Send check to: Behavioral Health Administration
Attn: Fiscal Department
Vocational Rehabilitation Building
55 Wade Ave.
Catonsville, MD 21228

Please email patricia.konyeaso@maryland.gov to confirm payment was sent.

| |
|-----------------------------------------------------------------------------------------------------------------------------------|
| <p>For Official Use: Date Invoice sent to Provider: _____ Date Payment received: _____ Deposit Date: _____</p> |
|-----------------------------------------------------------------------------------------------------------------------------------|

Maryland RecoveryNet – Critical Incident Report

Please email form to Patricia.Konyeaso@maryland.gov within **24 hours** of becoming aware of the incident.

Today's Date: _____ Date of Critical Incident: _____

Name/Title of Individual Completing Form: _____

Agency _____

Address: _____

City: _____ State: _____ Zip: _____

Location Where Incident Occurred:

Please check if individual is **NOT** a Maryland RecoveryNet service recipient { }

Individual involved in incident:

Name: _____

Date of Birth: _____ M-Number#: _____

Male Female Transgendered

List any other involved party:

Nature of Incident:

Death (from any cause after entry into *RecoveryNet* services)

Cause of death: _____

Suicide Attempt

Injury to self

Injury to or assault on others

Sexual/physical abuse or neglect, or allegation thereof

Incarceration

Inappropriate use of *RecoveryNet* funds

Other (please specify: _____)

Describe Incident:

Signature

Date

Name of Maryland RecoveryNet RAC _____

Summary: Privacy Rule for Health Insurance Portability and Accountability Act (HIPAA)
Published as 45 CFR parts 160 and 164 and effective in 2003, this Act protects the privacy of Protected Health Information (PHI) that is:

1. Transmitted by electronic media;
2. Maintained in any medium described in the definition of electronic media: or
3. Transmitted or maintained in any other form or medium.

As defined by HIPAA, *Protected Health Information* is any information, including demographic information, collected from an individual, that is:

1. Created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse;
2. Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and which is
3. Able to identify the individual, or with respect to which, there is reasonable basis to believe that the information can be used to identify the individual.

Business associate as defined by HIPAA (45 CFR section 160.103), is a person who, on behalf of the covered entity or provider or of an organized healthcare arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing; or
2. Any other function or activity regulated by this subchapter; or providers, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized healthcare arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

All providers who qualify as *covered entities* must comply with the provisions of the Privacy Rule of HIPAA. A *covered entity* is defined as a healthcare provider, a health plan, or a clearing house who transmits any health information in electronic form in connection with a transaction covered by this subchapter (section 160.103 of 45 CFR part 160). If this provider is a covered entity, then HIPAA requires the appropriate policies and procedures to be in place to comply with the HIPAA Privacy Rule. HIPAA requires such policies and procedures to include, but not be limited to, the following topics: Notice of Privacy Practices, Amendment of Protected Health Information (PHI), Recipient Access to PHI, Accounting of Disclosures, Workforce Training, Verification, Authorization for Disclosures of PHI, HIPAA Complaint Process, Marketing (if applicable), Research (if applicable), Audit and Monitoring or HIPAA compliance, and Business Associates Agreements with those companies providing goods and services which require the disclosure of PHI, etc.

Where existing confidentiality protections provided by CFR part 2, related to the release of alcohol and drug abuse records, are greater than HIPAA, then the department anticipates that the provider will consider any such provision of 42 CFR part 2 as the guiding language.

**Receipt of Services:
Transportation, Vital Documentation, Gap Services**

**Maryland RecoveryNet Receipt of Services
Transportation, Vital Documentation, Gap Services**

Service Recipient (Print): _____ Date: _____

Contact #: () _____ - _____ DOB: _____ M-Number _____

Service: [] Transportation card: Month _____

Vital Docs: [] Birth certificate [] MD ID

GAP: [] Transitional \$ _____ [] Clothing \$ _____

[] Supportive \$ _____ [] Medical \$ _____ [] Dental \$ _____
\$ to outside agency
(Name): _____

Care Coordinator Name (Printed) _____

Care Coordinator Signature _____ Date _____ Service Recipient Signature _____ Date _____

3/2015

MDRN Satisfaction Survey

Care Coordinators are responsible for ensuring that all service recipients complete this satisfaction survey at the time of follow-up or discharge. Completed surveys can be faxed to (410) 402-8601, mailed to the Behavioral Health Administration (BHA), 55 Wade Ave. Vocational Rehabilitation Building Catonsville MD 21228 ATTN: Maryland RecoveryNet Trish Konyeaso, or emailed to patricia.konyeaso@maryland.gov.

Region: _____

Care Coordination Agency: _____

Date _____

For each statement listed below, **please check the box** that most closely describes your experience with the Maryland RecoveryNet program.

| How satisfied were you with the assistance you received to obtain the following Recovery Support Services? | Very Satisfied | Satisfied | Slightly Satisfied | Not Satisfied | Does Not Apply |
|-------------------------------------------------------------------------------------------------------------------|----------------|-----------|--------------------|---------------|----------------|
| Recovery Housing | | | | | |
| Employment Services | | | | | |
| Transportation (Monthly card) | | | | | |
| Vital Documents (ID, Birth Certificates, Social Security card...) | | | | | |
| Halfway House | | | | | |
| Clothing | | | | | |
| Medical or Dental | | | | | |
| Other _____ | | | | | |
| Thinking about the MDRN services you received... How satisfied are you | Very Satisfied | Satisfied | Slightly Satisfied | Not Satisfied | Does Not Apply |
| With the services you received from your Housing provider? Name of Provider: | | | | | |
| With the services you received from your Care Coordinator? | | | | | |
| That you were treated with courtesy and respect. | | | | | |
| That your Care Coordinator made contact with you on a regular basis? | | | | | |
| That MDRN helped you achieve your personal and or recovery goals? | | | | | |
| Overall, how satisfied are you with the Recovery Support and Care Coordination services you received from MDRN? | | | | | |
| What service(s) did you need that MDRN did not offer? | | | | | |

**Maryland RecoveryNet
Housing Intake Form**

Service Recipient Name: _____

ValueOptions M-Number# _____ Date of Assessment _____

Referring Care Coordinator: _____ Referring Agency: _____

Gender: Male Female Transgendered If female, pregnant: Yes No

Smoker: Yes No Veteran Status: Yes No

Marital Status: Married Civil Union Divorced Separated Widowed

Never Married Other: _____

Legal Information/History

Pending Case(s): Yes No Previous Involvement with the Criminal Justice System: Yes No

Currently on probation? Yes No Parole? Yes No Number of arrests in last 30 days: _____

Mental/Physical Health

Does the service recipient have co-occurring behavioral or somatic health issues? Yes No

Diagnosis: _____

Explain _____

a) What is the plan for addressing physical health issues?

b) Is the service recipient currently on any psychotropic medications? Yes No

c) What medication/dosage? _____

d) What is the plan for on-going mental health counseling?

Is the service recipient seeing a psychiatrist or MH therapist? Yes No

Who? _____ Where? _____ Date of last visit _____

Does the service recipient have a history of self-injurious behavior? (suicidal, self-inflicted injury, etc.)

Yes No

Explain _____

Does the service recipient have PTSD diagnosis? Yes No

Has the service recipient been treated for PTSD? Yes No

What is the plan for managing the PTSD in recovery?

Does the service recipient have history of violent behavior expressed towards others? Yes No

Explain _____

Other State/Provider Agency Involvement

Where is the service recipient going for outpatient SUD treatment?

Name of program/contact info _____

Date of intake appointment _____

Are there any obstacles to participation in outpatient treatment? Yes No

Explain _____

Family and Support

Social Support (i.e. family, friends, etc.): Yes No

How would you describe your current relationship with your family members?

Does service recipient have a sponsor? Yes No Not sure

Does the service recipient have a Recovery Plan? Yes No

Housing Status

Living situation immediately prior to enrollment into State Care Coordination/MDRN:

| | | | | |
|-------------------|--------------------------|----------------------------|------------------------|--------|
| Private Residence | Single Room Occupancy | Residential Care/treatment | Hospital | Other: |
| Prison/Jail | Homeless Shelter | Homeless (i.e. street) | Inpatient (i.e. SA/MH) | |

Reason for leaving the last housing situation:

Have you been homeless within the last six months? Yes No

Are you at risk of homelessness? Yes No Not sure

What is the service recipient's housing goal?

What is the plan for paying for housing when RecoveryNet Services expire? _____

Has the service recipient ever lived in supportive or recovery housing? Yes No

When? _____

Where? _____

How Long? _____ How many times? _____