State of Colorado
Client Referral Form for Treatment of Alcoholism or Drug Abuse

Information to be completed by County

Client Name:	**Client Address:**	**Date:**
Client Social Security number:	**Client CBMS Number:**	**Client Phone Number:**
County Technician Name:	**County Technician Address**	
County technician Phone:	**County technician FAX number:**	
Assessment Center Name:	**Assessment Center Address:**	
Assessment Center Phone number:	**Assessment Center FAX number:**	

CLIENT RESPONSIBILITIES:

1. **I understand I am only eligible for State Aid to the Needy Disabled (AND) payments while I am actively participating in a treatment program.**
2. **I understand I will be discontinued from AND if I drop out of treatment for any reason.**
3. **I understand I will be discontinued from AND if I test positive for alcohol and/or drugs two times in any 3-month period.**
4. **I understand I am limited to 12 cumulative months lifetime benefits of State AND while my primary diagnosis is alcoholism or drug addiction.**
5. **I have received a copy of this notice, it was explained to me, and I agree to the responsibilities outlined above.**

Client signature		**Date**		**Technician Signature**		**Date**

Information to be completed by Treatment Center

Treatment Center contact person:	**Treatment Center contact person phone:**	**Treatment Center contact FAX number:**
Treatment Center Appointment date and time:		

Discontinuation of Client's Case

The information below is to be completed by the Treatment Center. Please check the appropriate reason(s) for discontinuation of the client's case, and mail for fax one copy to the county technician listed on the front side of this form.

Name of Client _____

Social Security Number of client

Check Here	Discontinue reason:
	The client did not show up for initial treatment appointment
	The client failed alcohol/drug test two times in 3-month period. The dates of the failed test were:
	The client failed to comply with treatment.
	The client withdrew or dropped out of treatment.

This form was faxed to the county technician on (Date):

Name of Treatment Center	Name of Treatment staff person (please print)
Phone number of staff person	Signature of staff person

Consent for the Release of Confidential Alcohol or Drug Treatment Information

I authorize the Managed Service Organization through the Alcohol and Drug Division, to disclose to the County Department of Social Services the following information:

Assessment and Referral Information

The purpose of this consent is to authorize disclosure of information from the MSO to the County Department of Social Services and the County Department of Social Services to the MSO,to establish eligibility for the State Aid to the Needy Disabled program (State AND).

I understand

- That my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.
- That the MSO cannot disclose my records without my written consent unless otherwise provided for in the regulations.
- That I may revoke this consent at any time with the understanding that revoking the consent will cause my state AND benefits to be discontinued.
- That this consent expires automatically at 60 days from the date of referral to the MSO.

Date	Signature of Recipient	Or	Signature of parent, guardian or authorized representative