Macomb County Community Mental Health
Office of Substance Abuse

SUD SPECIALTY SERVICES REFERRAL FORM INSTRUCTIONS
- FOR NON-FOCUS PROCESSING -

1. **The SUD Specialty Services Referral Form is to be used for NON-FOCUS processing, by:**

   a. **Programs that do not have access to the FOCUS data system;**
   b. **Any provider that temporarily does not have access to the FOCUS data system or on a limited basis;**
   c. **Any program where the client record is not in the FOCUS data system.**

2. **The completed Form, along with the Multiparty Release of Information and the client's current treatment plan, should be sent to the ACCESS CENTER (fax 586-948-0223) for processing as indicated at the top of the form.**

Substance Use Disorder Specialty Services Referral Form

Peer Recovery Coach, Case Management, Recovery Housing

Please use this form ONLY when unable to submit request through Change Level of Care Document in FOCUS

****Please send this form, a multi-party release of information, and a copy of the client's current treatment plan to Access Center via the FOCUS mail notification system, indicating "Referral For Services" in the message, or fax to 586-948-0223.****

Date: _____

Client Name: _____

Client Phone #: _____ **DOB:** _____ **Gender:** _____

City in Which Client Resides: _____

Drug of Choice: 1. _____ 2. _____ 3. _____

Current Treatment Provider: _____

Referring Counselor: _____ **Phone #:** _____

Current Funding Source - Clients must have one of the following **Macomb** County funding sources to qualify for services - **PLEASE CIRCLE ONE:**

Block Grant/PA2 **Medicaid** **Healthy Michigan**

Requested Service (Check all that apply):

___ Recovery Housing
___ Women's Specialty Case Management
___ Methadone Case Management
___ Peer Recovery Coaching

Areas of Need - *for all referrals* (Check all that apply):

___ Medical
___ Housing
___ Educational
___ Employment/Financial
___ Emotional Wellness / Mental Health
___ Other:_____
___ Transportation
___ Activities of Daily Living
___ Relationships and Social Support
___ Leisure and Recreation
___ CPS Involvement

Clients who may qualify for Peer Recovery Coaching include: (Check areas that apply)

___ Individuals with multiple/prior unsuccessful treatment attempts
___ Individuals who are engaged in treatment and ready to take action
___ Individuals waiting for placement into higher level of care (residential or methadone)
___ Individual with at least one 'Area of Need' indicated above

Comments: _____

_____

_____

Client/Resident Name:_____ (Print) Date of Birth_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG INFORMATION BETWEEN MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE, and FUNDED PROVIDERS

I, _____, authorize
(Name of Client/Resident)

Macomb County Access Center,
(Access and Referral Agency)

and

Macomb County Office of Substance Abuse (MCOSA),
(Funding Agency)

and

Adult Well-Being, CARE of Southeastern Michigan, BioMed, Clearview, Clinton Counseling Center, CCC-Jail Program, Community Programs, Inc./Meridian Health Services, Eastwood Clinic, Kairos Healthcare, Macomb Family Services, Sacred Heart, Turning Point
(MCOSA Contracted Agency)

and

Eastland House, Hollywood Houses, and Else and Willard Houses ¾ Living Recovery Homes
(MCOSA Contracted Recovery Homes)

to communicate with and disclose to one another the following information:
My name and other personal identifying information; my current and past status as a client/resident at any of the agencies listed above; my treatment and recovery plan information; initial and subsequent evaluations of my service needs; alcohol/drug and mental health recommendations and rationale for referral(s); summary of treatment progress and compliance; appointments scheduled and attendance; discharge plan; drug/alcohol testing results; other: _____.

The purpose of the disclosures authorized in this consent is, per my request, to provide these agencies with the information they need to: coordinate my treatment needs, determine my readiness and/or ability to participate in treatment/recovery services, and arrange/authorize appropriate services/payment to meet my needs and/or assist in my recovery plan.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **twelve months from date signed.**

Dated:_____ _____
Signature of Client/Resident