Living Opportunities of DePaul Licensed Housing Application Cover Sheet

Applicant’s Name: ___________________________ Date Completed: ________________

Please check the type of housing the applicant is interested in:

<table>
<thead>
<tr>
<th>GENESEE COUNTY</th>
<th>ORLEANS COUNTY</th>
<th>WYOMING COUNTY</th>
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</thead>
</table>
| □ Batavia Apartment Treatment Program  
555 East Main Street  
Batavia, NY 14020 | □ Orleans County Apartment Treatment Program  
Crimson Heights Apts.  
345 Crimson Drive  
Albion, NY 14411 | □ Wyoming County Apartment Treatment Program  
35 Culver Avenue Ext.  
Warsaw, NY 14569 |

ERIE COUNTY Referrals must be submitted through the Erie County Department of Mental Health SPOA System at: https://familyfirst.secure.force.com/spoa/apex/spoa2_home

Please send completed referrals to: Intake Department  
Living Opportunities of DePaul  
2475 George Urban Boulevard, Suite 201  
Depew, NY 14043  
(716) 391-5400  
Fax: (716) 608-0131

In accordance with federal, state and municipal fair housing laws no person shall be denied housing because of his/her race, color, religion, national origin, sex, marital status, age, disability, family status, sexual orientation or income.
Descriptions of Licensed Housing Programs

LICENSED HOUSING

**Apartment Treatment Programs** provide consumers with the highest level of independence in a program licensed by the New York State Office of Mental Health. Programs offer one- and two-bedroom apartments with staff who make routine visits and are available 24-hours a day in case of an emergency. The programs are designed to be a preparatory step before the consumer begins to live independently within the community. An emphasis is placed on increasing personal initiative and self-reliance. Cash allowances for groceries are provided. Residents are expected to develop individual goals that focus on living more independently. The typical length of stay is eighteen to twenty-four months.

**Community Residence-Single Room Occupancy (CR-SRO) Programs** provide housing in a service-enriched, recovery-oriented setting to adults with a psychiatric disability. The programs are licensed by the New York State Office of Mental Health and have a residential atmosphere with individual bedrooms, inviting common areas and outdoor courtyards. Other services include 24-hour staffing, daily living skills training, crisis management, medication management; linkages to medical and dental care and health education services; social/recreational assistance, and vocational/educational services among others.

**Licensed Congregate Treatment Sites** (also known as group homes) provide a comprehensive level of staff support, while encouraging independence, in a program licensed by the New York State Office of Mental Health. The program is sometimes the entry point to all certified programs and provides 24-hour on-site staffing, meals, support, advocacy and recovery-oriented services. Sites house ten residents each who are 18 years of age or older. To further enhance self-esteem and growth, an emphasis is also placed on consumer involvement in activities outside the residential setting including personalized recovery oriented services programs, vocational programs, school, and competitive- and non-competitive employment. These sites are considered transitional and rehabilitative in nature, as the resident’s goal is to move to a more independent living environment within twenty-four months.
For Housing Provider Use Only

Date Rec’d: ___________________________ Disposition: ___________________________

* Items are required fields

I. **APPLICANT DATA**

*Name: ________________________________  *Social Security Number: ________________
  (Last)  (First)  (Middle)

*Current Address: ________________________________  *Telephone #: ___________________________
  (City)  (State)  (Zip Code)

* Months in current living situation: ________________

Previous Address: ________________________________  *County: □ Erie □ Other: ________________

* Date of Birth: _____ / _____ / ______  *Sex: ______  Race (optional): ___________________________

* Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Religion (optional): ___________________________

* Highest Level of Education Completed: ____________________________  Literate: ___ Yes ___ No

* Family Contact: ________________________________  Relationship: ___________________________

Address: ____________________________________  Telephone #: ___________________________
  ____________________________________  Email: ___________________________

*II. **DIAGNOSIS (DSM V CODE)**

AXIS I  AXIS I
AXIS II  AXIS II
AXIS III  AXIS III

AXIS IV (A) Stressor ____________________________ (B) Severity __________________  (C) Duration __________

AXIS V (A) Current GAF Score ____________________________  Past Year GAF Score (if available) ____________________________

(ENTER TWO DIGIT SCORES FROM 01-90)

Intellectual Level (IQ) ____________ Below 70 ____________ 70-84 ____________ Above 84

III. **REFERRED BY**

Name: ____________________________________  * Telephone #: ___________________________

Agency: ____________________________________

Program: ____________________________________  Contact (if other than above): ___________________________

Address: ____________________________________  Email: ___________________________

3
IV. **RISK ASSESSMENT**

Is the consumer identified as high-risk, high-need due to any one of the following characteristics?

**YES**  **NO**  **DON’T KNOW**

☐  ☐  ☐  A history of sexually abusing others
☐  ☐  ☐  A history of fire setting
☐  ☐  ☐  A history of indiscriminate serious assault (consumer arrested and/or victim required medical attention)
☐  ☐  ☐  A history of homicide
☐  ☐  ☐  A history of suicide attempts
☐  ☐  ☐  A history of repeated episodes of serious self-harm requiring medical attention
☐  ☐  ☐  Three episodes of housing loss in the last 12 months
☐  ☐  ☐  Medical needs that cannot be addressed by the housing provider
☐  ☐  ☐  History of alcohol abuse/dependence
☐  ☐  ☐  History of substance abuse/dependence (if yes, note below, onset and frequency of use, type of substance, date of last use and method of administration)
☐  ☐  ☐  History of arrests and dispositions (i.e. currently in jail or facing charges, released from jail or prison within the last year, probation/parole supervision, CPL 33.20, Alternative to Incarceration, etc.)

If you answered yes to any of the above, please provide details in the space below or include in psychosocial history:

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

Describe signs of decompensation and/or prodromal symptoms:  _____________________________________________________

___________________________________________________________________________________________________________

V. **FUNCTIONAL STRENGTHS AND DEFICITS**

Does applicant currently:                                Independently  Needs Help  Unable  Unknown

- Manage personal needs (grooming/hygiene/laundry)    ☐  ☐  ☐  ☐
- Budget money                                         ☐  ☐  ☐  ☐
- Respond appropriately to emergency situations (e.g. fire, First Aid) ☐  ☐  ☐  ☐
- Comply with medication regimen                       ☐  ☐  ☐  ☐
- Use public transportation and other community resources ☐  ☐  ☐  ☐
- Plan menus, grocery shop, prepare meals             ☐  ☐  ☐  ☐
- Self-medicate                                        ☐  ☐  ☐  ☐

VI. **Please attach copies of most recent progress notes, service plan reviews and psychiatric evaluations or psychosocial history.**
**VI. SOURCE OF INCOME/FINANCIAL RESPONSIBILITIES**

Please check all that apply:

- [ ] **No Assets or Funding Source**
- [ ] **Public Assistance**
  - [ ] Active Monthly Amount $ ____________ County ____________ Telephone # ____________
  - [ ] Pending Application Date ____________ Case Worker: ____________________________
- [ ] **Supplemental Security Income (SSI)**
  - [ ] Active Monthly Amount $ ____________ County ____________ Telephone # ____________
  - [ ] Pending Application Date ____________ Overpayment? __________ SSI Worker ____________
- [ ] **Social Security (SSD or SSA)**
  - [ ] Active Monthly Amount $ ____________ Type of Benefit (i.e. Disability) __________ Claim # __________
- [ ] **Payee Status**
  - [ ] **Self**
    - [ ] Representative: Name: __________________________ Telephone #: ____________
    - [ ] Address: __________________________ Email: __________________________
- [ ] **Wages** (including Sheltered Workshop)
  - [ ] Full Time
  - [ ] Part Time
- [ ] **Union Benefits** $ ____________/ month
- [ ] **Unemployment Insurance Benefits** $ ____________/ month
- [ ] **New York State Disability** $ ____________/ month
- [ ] **Railroad Retirement Benefits** $ ____________/ month
- [ ] **Workers’ Compensation Benefits** $ ____________/ month
- [ ] **Pension/Annuity** $ ____________/ month
- [ ] **Veterans Benefits** $ ____________/ month

**Other Assets**

- [ ] Alimony / Child Support Received $ ____________/ month
- [ ] Homeowner
- [ ] Bank Account(s) – List Banks: __________________________
- [ ] Stocks
- [ ] Bonds
- [ ] Trusts
- [ ] Burial Fund
- [ ] Motor Vehicle
- [ ] Life Insurance

**Food Stamps**

- [ ] Active Amount $ ____________/ month
- [ ] Pending Application Date ____________

**Health Insurance**

- [ ] Medicaid # ____________ Access # ____________ Seq. # ____________
- [ ] Medicare # ____________
- [ ] Other: Type __________________________ Policy # ____________

**Financial Responsibilities**

- [ ] No Known Financial Responsibilities
- [ ] Student Loan $ ____________
- [ ] Medical Expenses $ ____________
- [ ] Alimony / Child Support $ ____________
- [ ] Motor Vehicle $ ____________
- [ ] Other ____________
QVII. **PREVIOUS RESIDENTIAL SERVICES**

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<tr>
<th>AGENCY</th>
<th>ADMISSION DATE</th>
<th>DISCHARGE DATE</th>
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QIX. **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS / INSTITUTIONALIZATIONS**

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>SERVICE (I.E. detox)</th>
<th>ADMISSION DATE</th>
<th>DISCHARGE DATE</th>
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ER VISITS (list dates over the last 6 months)

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QX. **PREVIOUS OUTPATIENT TREATMENT / CASE MANAGEMENT SERVICES**

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>TYPE OF SERVICE</th>
<th>ADMISSION DATE</th>
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XI. **CURRENT OUTPATIENT TREATMENT**

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<tr>
<th>Agency</th>
<th>Address</th>
<th>Contact</th>
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<tr>
<th>Telephone</th>
<th>Date Linkage Completed</th>
<th>Prescribing Psychiatrist</th>
<th>Telephone #</th>
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XII. **CURRENT CARE COORDINATION / CASE MANAGEMENT**

- [ ] None
- [ ] ACT
- [ ] ICM
- [ ] TCM
- [ ] SCM
- [ ] Other Case Management

- [ ] Active
  - Agency __________________

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<tr>
<th>Case Manager’s Name</th>
<th>Telephone #</th>
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- [ ] Pending – Referral has been made
- [ ] Assisted Outpatient Treatment (A.O.T.)
Applicant’s Name: ________________________________

MEDICATION                              DOSAGE                              FREQUENCY

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

*XIII. CURRENT COMMUNITY REHABILITATION AND SUPPORTS
(If an activity or support is pending or recommended, please note in comment section.)

☐ IPRT  Agency __________________________  Contact ________________  Tel __________

☐ Work Agency __________________________  Contact ________________  Tel __________

☐ C.D.T. Agency __________________________  Contact ________________  Tel __________

☐ P.R.O.S. Agency __________________________  Contact ________________  Tel __________

☐ Peer Services Agency __________________________  Contact ________________  Tel __________

☐ Self-Help Groups Agency __________________________  Contact ________________  Tel __________

☐ Social Clubs Agency __________________________  Contact ________________  Tel __________

☐ Clubhouses Agency __________________________  Contact ________________  Tel __________

☐ School Agency __________________________  Contact ________________  Tel # __________

Please note days and hours of activities below:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Comments:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Other Social Supports: ☐  Family  ☐  Job  ☐  Other ______________________________

* Transportation Access: ☐  Public  ☐  Own Car  ☐  Program Van  ☐  Family  ☐  Medicaid Cab

*XIV  CURRENT HEALTH CARE PROVIDER
Clinic __________________________  Contact ________________  Tel # __________
Primary Care Physician __________________________
Address __________________________

Advanced Directive: ☐  Yes  ☐  No
Contact Person: __________________________  Telephone # __________
Email: __________________________
XV. **MEDICAL EXAMINATION**

Date of most recent medical examination: ________________________________________

(Completed by a Physician, Nurse Practitioner or Physician Assistant)

A current (within 12 months) and legible history and physical examination may be substituted for the information requested below.

Please check ALL that are current or historic medical concerns. If yes, please comment:

<table>
<thead>
<tr>
<th>Medical Concern</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Comments</th>
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<td>Allergies/Medication Sensitivity</td>
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<td>Hearing Impairment</td>
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<td>History of Cancer</td>
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<td>Lung Disease</td>
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<td>Mobility Limitations</td>
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<td>Podiatry</td>
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<td>Skin Disorder</td>
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<td>Special Diet(s)</td>
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<tr>
<td>Speech Impairment</td>
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<td>Tuberculosis</td>
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<tr>
<td>Visual Impairment</td>
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Other (Please Specify): ________________________________________________________

__________________________________________________________________________

For any of above conditions checked YES, please indicate specific instructions to be followed by the applicant:

__________________________________________________________________________

__________________________________________________________________________

Signature and title of person completing this form: ____________________________

Date: ____________________________
XVI. **TUBERCULOSIS TEST RESULTS**
(Completed by a Physician, Nurse Practitioner or Physician’s Assistant)

It is necessary that all applications be screened for tuberculosis within *one year* of the referral. The following documentation is required. Medical records verifying administration of the PPD test may be submitted in lieu of this form.

- **Date of PPD (Mantoux) Test**

- **PPD (Mantoux) Test Administered by**

- **Results of PPD (Mantoux) Test**

- **Date of Chest X-Ray (if indicated)**

- **Results of Chest X-Ray**

- **Signature and credentials of person completing this form**

- **Date**
PHYSICIAN’S AUTHORIZATION FOR
REHABILITATIVE SERVICES OF COMMUNITY RESIDENCE

DePaul
2475 George Urban Boulevard
Suite 201
Depew, New York 14043
Phone: (716) 391-5400

Initial Authorization (face to face)
Semi-Annual Authorization (CR)
Annual Authorization (TAP)

Client’s Name: ________________________________

Client’s Medicaid Number: ______________________

Based on review of the assessments made available to me, or as the result of a face to face
assessment with the client in need of an initial authorization, I, the undersigned licensed
physician, have determined that this individual would benefit from the provision of mental health
rehabilitation services provided in a congregate care residential setting as defined pursuant to
Part 593 of 14 NYCRR.

Period Covered:

______/ ___/ ______ to ________/ ___/ ______
Month Day Year Month Day Year

Primary Mental Health Diagnosis and ICD-10 Code

__________________________________________
M.D. License Number

__________________________________________
Print Name of M.D. M.D. Signature Date
COMMUNITY REHABILITATION SERVICES NOTATION CODES

AT - Assertiveness/Self Advocacy Training - Training which promotes the individual’s ability to assess his or her needs to make a life status change and to increase self-awareness about his or her values and preferences. Training is intended to increase an individual’s ability to respond to medical, safety and other personal problems. Activities are also intended to improve communication skills and facilitate appropriate interpersonal behavior.

CI - Community Integration Services/Resource Development - Activities designed to help individuals to identify skills and community supports necessary for specific environments; to assess their skill strengths and deficits in relationship to environmental demands; to assess resources available to help the individual; to develop a natural support system; by accessing social, educational and recreational opportunities.

DLS - Daily Living Skills Training - Activities which focus on the acquisition of skills and capabilities to maintain primary activities of daily life; services are provided by addressing areas of functioning in categories such as: dressing, personal hygiene and grooming, selection and/or preparation of food, cleaning and washing of clothes, maintenance of environment, budgeting and money management. Training is intended to increase those competencies needed by the individual to live in his or her goal environment.

HS - Health Services - Training to maximize independence in personal health care by increasing the individual’s awareness of his or her physical health status and the resources required to maintain physical health; including regular medical and dental appointments, basic first aid skill, basic knowledge of proper nutritional habits and family planning. Also, includes training on special topics such as AIDS awareness.

MMT - Medication Management and Training - The storage, monitoring, record keeping and supervision associated with the self-administration of medication. This does not include prescribing, but does include a certain degree of reviewing the appropriateness of the residents’ existing regimen with the appropriate physician. Activities which focus on educating residents about the role and effects of medication in treating symptoms of mental illness and training in the skill of self-medication are also included.

PT - Parent Training - Structured activities intended to promote positive family functioning and enable the resident to assume parenting responsibilities. Activities include peer support groups to foster skills around effective parenting, assistance in selecting and obtaining housing appropriate for families, and linkage with the children’s service system. Psycho-education programs on parenting skills, single parenting issues, child care and the nature of mental illness and its effect on the family are also included.

RC - Rehabilitation Counseling - A therapeutic modality which includes assisting the individual in clarifying future directions and the potential to achieve rehabilitation goals; identifying and specifying behaviors that impede goal setting; improving understanding regarding the influence of environmental stress; and helping an individual to apply newly learned behaviors to housing and other situations outside the program structure.

SD - Skill Development Services - Activities which assist clients to gain and utilize the skills necessary to undertake employment or pursue educational opportunities. This may include skills related to securing appropriate clothing, scheduling, work related symptom management, and work readiness training.

S - Socialization - Activities whose purpose are to diminish tendencies toward isolation and withdrawal or overly aggressive behavior by assisting residents in the acquisition or development of social and interpersonal skills. “Socialization” is an activity whose purpose is to improve or maintain a resident’s capacity for social involvement by providing opportunities for application of social skills. This occurs through resident/staff interaction in the program and through exposure with staff to opportunities in the community. Modalities used in socialization include individual and group counseling and behavior interventions.

SAS - Substance Abuse Services - Services provided to increase the individual’s awareness of alcohol and substance abuse and reduction or elimination of its use; including verbal and medication therapies, psycho-educational approaches, and relapse prevention techniques.

SM - Symptom Management - Activities to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of residents’ mental illness symptoms and response to treatment, interventions designed to help residents manage their symptoms, and assisting residents to develop coping strategies to deal with internal and external stressors. Services range from providing guidance around everyday life situations to addressing acute emotional distress through crisis management and behavior intervention techniques.
LICENSED HOUSING CHECKLIST

Please utilize this checklist to ensure the Licensed Housing Referral Application is complete.

☐ Licensed Housing Cover Page (page 1)
☐ Licensed Housing Application Information (page 3)
☐ Housing Risk Assessment (page 4)
☐ Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults (page 5)
☐ Functional Assessment Worksheet (page 6)
☐ Medical and Health Information (page 7 & 8)
☐ Physician Authorization for Rehabilitation Services of Community Residences (page 9 & 10)
☐ Psychiatric Assessment completed within the past 12 months.
☐ Psychosocial History. To include documentation regarding signs of decompensation and/or prodromal symptoms, risk behaviors, legal history, substance abuse, general health and personal & family history.
☐ Authorization for release of information
DePaul
AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

A representative from DePaul must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your representative should read the descriptions below before signing this form.

NAME: ___________________________________________ DOB: ____________________________
I hereby give permission to: ___________________________ Living Opportunities of DePaul
□ receive information from:  OR  □ release information to:
PERSON/ORGANIZATION: ___________________________________________
ADDRESS: ___________________________________________
TELEPHONE _______ NUMBER: _______
INFORMATION: ___________________________________________
□ Academic Performance/Vocational □ Psych/Social Assessment
□ Financial □ Residential Functioning
□ Discharge Summaries □ Treatment Plan (Mental Health)
□ Intake/Screening Assessment □ Treatment Plan (Addiction)
□ Medical History, Physical Findings, Lab reports □ Legal
□ Medication Record □ Insurance
□ Psychiatric Evaluation/Status □ Psychological Evaluation
□ Progress Notes □ Dates in Program
□ Medication Orders □ Physician’s Orders
□ Other (please specify) ___________________________________________

THIS INFORMATION IS NEEDED FOR: ___________________________________________
Psychiatric Treatment Services □ Family/Significant Other Communication
Medical Treatment Services □ Adult Day Care Coordination
Financial LINKAGE □ At the request of the individual
Housing Support Services □ Other (please specify)
□ Vocational Linkage/Coordination

I hereby authorize the release of the above Protected Health Information from my record. I understand that the information to be released from my record is confidential and protected from disclosure by Federal and State Confidentiality Rules. *

My authorization to release information to the person/organization/facility/program identified above, WILL EXPIRE ON ___/___/____ OR WHEN I AM NO LONGER RECEIVING SERVICES from such person/organization/facility/program, unless otherwise specified. I understand if I sign this authorization, I will have the right to revoke it at any time, except to the extent the program has already taken action based upon my authorization. I also have a right to receive a copy of this form after I have signed it.

Signature of Client/Consumer ___________________________ Date ___________________________
Printed Name of Client/Consumer ___________________________________________
Signature of Witness ___________________________ Date ___________________________
Printed Name of Witness ___________________________________________

PLEASE NOTE: HIV/AIDS related information cannot be released under this form. A specific form exists for the release of HIV/AIDS information.

__________________________ ___________________________
Signature of Client/Consumer Date Printed Name of Client/Consumer

__________________________ ___________________________
Signature of Witness Date Printed Name of Witness

*With the exception of Substance Abuse Information, information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule for Substance Abuse Programs—the information disclosed is protected by Federal Law and the recipient cannot make any further disclosure unless permitted by regulations.