Consent for Services

I, _____, understand I am voluntarily agreeing to services at Center For Family Services. I also understand that I cannot be compelled to accept services. This consent form must be signed prior to receiving services. If I choose not to consent, I will not receive services at this time. I also understand that I cannot be compelled to accept services, except in an emergency. This does not limit me from receiving services in the future. I also understand that once I consent to services, I can revoke at any time.

Center For Family Services staff have informed me of agency and program services that may be beneficial to me. I understand that there are advantages and possibly some disadvantages of these services and this has been explained to me.

I have received and understand the grievance procedure (see Client Rights and Responsibilities), if I have complaints or concerns about the services offered and or my rights as a consumer at any time.

In order that I may benefit from the services provided by Center For Family Services, I hereby consent to participate in services, which are deemed beneficial to me.

I have received a copy of the documents and consents listed below. These consents were reviewed with me by the staff at Center For Family Services. I have had a chance to review these forms and ask any questions.

By signing this acknowledgement form, I consent to services at Center For Family Services, including these documents.

- **Consent for Remote Teleservices** ☐ Yes ☐ No ☐ Not Applicable
- **Charitable Choice Notice** ☐ Yes ☐ No ☐ Not Applicable
- **Client Notice: Federal Law 42 CFR Part 2** ☐ Yes ☐ No ☐ Not Applicable
- **Consent for Follow Up Records** ☐ Yes ☐ No ☐ Not Applicable

- **Referral for Tuberculosis and HIV/AIDS Pre- and Post-Test Counseling** ☐ Yes ☐ No ☐ Not Applicable
- **Client Rights and Responsibilities, including Grievance Procedure** ☐ Yes ☐ No ☐ Not Applicable
- **Group Rules** ☐ Yes ☐ No ☐ Not Applicable
- **Agency Statement of Client's Rights and Agreement to Accept Treatment** ☐ Yes ☐ No ☐ Not Applicable
- **Agreement for Payment** ☐ Yes ☐ No ☐ Not Applicable
- **Notice of Privacy Practices** ☐ Yes ☐ No ☐ Not Applicable
- **Intern Services Disclosure** ☐ Yes ☐ No ☐ Not Applicable

_____ _____

Signature of Client Date

_____ _____

Signature of CFS Worker Date

_____ _____

Signature of Parent / Guardian Date

_____

Description of Authority (if signing on behalf of client)

CLIENT INTAKE FORM
Center For Family Services
Substance Use Treatment Programs

Name: _____ Date: _____
Address: _____ Pronouns _____
_____ DOB: _____
_____ SS# _____
County: _____
Phone: _____

May we use this address for mailing purposes?
☐ Yes ☐ No
May we contact you by phone?
☐ Yes ☐ No

Drug: _____ Last Use: _____
Alcohol: _____ Last Use: _____

Relationship Status: _____
Gender Identity: _____
Sexual Orientation: _____

1. Who is referring you to Center For Family Services/Substance Use Treatment Program?

☐	DCP&P	Caseworker:
☐	Probation	Probation Officer:
☐	Parole/ISP	Probation Officer:
☐	Drug Court	Probation Officer:
☐	IDRC	
☐	WFNJ/SAI	Worker:
☐	Self-Referral	

2. Have you had previous drug/alcohol treatment? ☐ Yes ☐ No
   If yes, where and when? _____
3. Have you ever been treated at Center for Family Services? ☐ Yes ☐ No
4. Are you presently on any medication? ☐ Yes ☐ No
   If yes, name of medication? _____
5. Are you presently being treated for any medical/psychiatric condition? ☐ Yes ☐ No
   If yes, name and location of doctor/psychiatrist. _____

Medical Emergency Contact Information

Client Name: _____

I hereby give consent to Center For Family Services, Inc., to contact the following individuals in case of medical emergency:

Emergency Contact Name	Relationship of Contact	Contact Home Phone number	Contact Cell Phone
1.			
2.			

Children's Medical Emergency Contact Information

If children are not present at treatment, check N/A: ☐

Child(ren) Name(s): _____

I hereby give consent to Center For Family Services, Inc., to contact the following individuals in case of medical emergency for the above named child(ren):

Emergency Contact Name	Relationship of Contact	Contact Home Phone number	Contact Cell Phone
1.			
2.			

I understand and acknowledge the importance of having up-to-date personal and emergency information on file with the Center for Family Services and will notify my counselor immediately about any change in phone numbers or contact information.

Client Signature: _____ Date: _____

NOTICE TO RECIPIENT

This information has been disclosed to you from records, which may be 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 individual with substance use disorder.

Vision, Hope, and Strength for a Better Life

FEDERAL CONFIDENTIALITY
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, of _____,
(Client's Name) (Client's Address)

Authorize: Center For Family Services: Program: Pathways to Recovery Adult Substance Use Program

594 Benson Street, Camden, NJ 08103 (856) 963-0220

(Address) (Phone #) (Fax #)

To disclose and exchange the following information (*describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible)*:

Please check any of the following:

- ☐ Presence in Treatment
- ☐ Changes in meeting dates and/or times
- ☐ Messages to contact counselors
- ☐ Name of agency

This information is to be released **to whoever answers the following phone:**

Phone Number: _____

For the following purpose *(describe the purpose of the disclosure; as specific as possible)*: To be able to reach the client by telephone, call or text regarding treatment, scheduling and appointments. This information may be given as needed.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.

I also understand that I may revoke this consent at any time, ***in writing***, except to the extent that action has been taken in reliance on it.

I further acknowledge that the information to be released was fully explained to me and this consent is given on my own free will. Client has been provided a copy of this form. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

This authorization to release information will expire, if not revoked by me, **1 year from admission date.**

_____ _____
Signature of Client Date Signature of CFS Staff Date

_____ _____
Signature of Parent / Guardian Date Description of Authority if signing on behalf of client

NOTICE TO RECIPIENT

This information has been disclosed to you from records, which may be 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 individual with substance use disorder."

PROOF OF INCOME ATTESTATION

I, _____, hereby attest that I have no forms of income verification available, and that my yearly income is _____.

_____ _____

Signature Date

INCOME AND INITIATIVE ELIGIBILITY SCREEN

"In order to receive public funding for substance abuse treatment you must complete the Income and Initiative Eligibility screening, otherwise you will be responsible for payment."

Do you wish to compete this screening: YES☐ NO☐

_____ _____

Print Name Signature/Date

IME CONSENT FORM

CONSENT FOR THE RELEASE OF CONFIDENTIAL SUBSTANCE USE TREATMENT INFORMATION

Client Name: _____ **Date of Birth:** _____

AUTHORIZATION & ACKNOWLEDGEMENTS

I, _____, authorize _____ **(Provider Agency)**, Rutgers University Behavioral Health Care (UBHC) in the capacity of the **Interim Management Entity (IME)** and the **New Jersey Department of Human Services/Division of Mental Health and Addiction Services (NJ DHS/DMHAS)** to communicate with and disclose to one another information about my substance use treatment.

The purpose of the authorized disclosure is to enable _____ **(Provider Agency)**, UBHC in the capacity of the **IME** and the **NJ DHS/DMHAS** to provide me with better, more coordinated treatment and allow for the evaluation and authorization of my treatment. I understand that the information available to these entities will be exchanged verbally and electronically through the **New Jersey Substance Abuse Monitoring System (NJSAMS)**, a secure computer system, and that my information will be maintained in the NJSAMS.

I understand that my medical records are protected under federal and state law, including 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), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may be denied services if I refuse to consent to a disclosure for the purpose of treatment, payment or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

DESCRIPTION OF INFORMATION TO BE DISCLOSED/RELEASED:

All my health information, including my drug and/or alcohol treatment record and records about other conditions, including medical and mental health conditions, for which I might have received treatment.

TERM/EXPIRATION/REVOCATION

This signed Consent will expire one year from today and will remain in effect until that date. 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.

SIGNATURES

Client Signature: _____ **Date:** _____

Signature of Responsible Party if other than Client: _____ Date: _____

Describe authority to sign on behalf of Client: _____

Witness Signature: _____ **Date:** _____

Why do I need to sign the IME Consent Form?

By signing the IME Consent Form, you are allowing your identified substance use disorder treatment provider, the NJ Department of Human Services/Division of Mental Health and Addiction Services (NJ DHS/DMHAS) and the Interim Management Entity (IME) to communicate about your health information and records in order to provide you with better, more coordinated substance use treatment. As part of this communication, your health information will be disclosed through a computer system, the New Jersey Substance Abuse Monitoring System (NJSAMS).

Here is some additional information about the IME Consent Form:

- You can withdraw your consent at any time. You may be asked to sign a form indicating that you have withdrawn your consent.
- A refusal to consent or a withdrawal of consent may affect your ability, or continued ability, to receive services if it affects disclosures related to treatment, payment or other health care operations.
- Any health information about you may not be re-disclosed to others except as allowed by state and federal laws and regulations.
- You are entitled to a copy of the IME Consent Form after you sign it.
- Your current substance use treatment provider identified in the IME Consent Form must obtain a separate consent in order to communicate with and disclose information about you to any other substance use treatment providers and/or health care professionals for whom you are a current, former or future client.

What is NJSAMS?

NJSAMS is a secure web-based computer system that collects and maintains demographic, clinical, service and financial information about clients who receive substance use disorder treatment in New Jersey. Examples of the information collected and maintained in NJSAMS include admission and discharge dates, income, household size and clinical assessments. All New Jersey substance use disorder treatment programs and facilities are required to record and report client data to the NJSAMS.

By recording your information in NJSAMS, your substance use disorder treatment provider, the IME and NJ DHS/DMHAS can better coordinate your treatment, including obtaining any necessary authorizations for assessments and other services. In addition, de-identified data is used to assist the NJ DHS/DMHAS in program development and budget planning, and for required data reporting to the federal government.

What is the IME?

The NJ DHS/DMHAS has contracted with Rutgers University Behavioral Health Care to serve as the IME for addiction services. The IME is a central point of access for individuals seeking treatment for substance use disorders and maintains a 24/7 call center. The IME is designed to provide services including, but not limited to, screening, referral, care coordination and utilization management (e.g. authorizations for assessments, treatment placements and continuing care).

The IME also assists NJ DHS/DMHAS and NJ FamilyCare/Medicaid with verifying an individual's financial eligibility and provider network management activities. These activities allow the IME to refer callers to providers that are most likely to meet their service need and have the ability to use funding or insurance for which the caller qualifies.

For more information about the IME, please visit:

http://www.state.nj.us/humanservices/dmhas/initiatives/managed/

Vision, Hope, and Strength for a Better Life

AUTHORIZATION FOR RELEASE OF INFORMATION
For Ongoing Collaborative Service Providers

I, _____, of _____,
(Client's Name) (Client's Address)

Authorize: Center For Family Services: Program: Pathways to Recovery Adult Substance Use Program

594 Benson Street, Camden, NJ 08103 (856) 963-0220

(Address) (Phone #) (Fax #)

And: Trinity Medical Laboratories

(Name of Organization / Name of Service Provider)

_____

(Names of persons at listed entity, if an established treating provider relationship does not exist)

3 Eves Drive, Suite 300, Marlton, NJ 08053 (856) 334-9496 (856) 437-5611

(Address) (Phone #) (Fax #)

To disclose and exchange the following information (*describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible)*:
Demographic information, medical history, current and history of medication(s), substance use disorder history and specimen for testing

For the following purpose *(describe the purpose of the disclosure; as specific as possible)*: to obtain substance use analysis, such as urinalysis, results to enable an appropriate continuum of care.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.

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.

I further acknowledge that the information to be released was fully explained to me and this consent is given on my own free will. Client has been provided a copy of this form.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

This authorization to release information will expire, if not revoked by me, in one year, or on the following date:

_____
(Expiration Date – not to exceed 365 days)

_____ _____
Signature of Client Date Signature of CFS Staff Date

_____ _____
Signature of Parent / Guardian Date Description of Authority if signing on behalf of client

NOTICE TO RECIPIENT

This information has been disclosed to you from records, which may be 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 individual with substance use disorder."

Vision, Hope, and Strength for a Better Life

AUTHORIZATION FOR RELEASE OF INFORMATION
Federal Confidentiality Relese of Information

I, _____, of _____,
(Client's Name) (Client's Address)

Authorize: Center For Family Services: Program: Pathways to Recovery Adult Substance Use Program

594 Benson Street, Camden, NJ 08103 (856) 963-0220

(Address) (Phone #) (Fax #)

And: My Family Member

(Name of Organization / Name of Service Provider)

_____

(Names of persons at listed entity, if an established treating provider relationship does not exist)

_____

(Address) (Phone #) (Fax #)

To disclose and exchange the following information (*describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible)*:

content of SUD evaluation, SUD diagnosis, prognosis and progress, and alcohol/drug screen results, treatment recommendations, presence in SUD program, attendance, progress,

discharge circumstances, discharge summary and recommendations for further treatment, including all information relating to my substance use disorder treatment

For the following purpose *(describe the purpose of the disclosure; as specific as possible)*: to enhance the support of family and significant other and/or for participation in family group sessions. This information may be given in person or by phone.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.

I also understand that I may revoke this consent***, in writing,*** at any time, except to the extent that action has been taken in reliance on it.

I further acknowledge that the information to be released was fully explained to me and this consent is given on my own free will. Client has been provided a copy of this form.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

This authorization to release information, if not revoked by me, will **expire two weeks after discharge.**

_____ _____
Signature of Client Date Signature of CFS Staff Date

_____ _____
Signature of Parent / Guardian Date Description of Authority if signing on behalf of client

NOTICE TO RECIPIENT

This information has been disclosed to you from records, which may be 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 individual with substance use disorder."