Livery Transportation Supplement
for the
Behavioral Health Recovery Program (BHRP)

INSTRUCTIONS FOR SERVICE / TREATMENT PROVIDER:

- Contact the livery vendor (203-401-2088) directly to make arrangements for the transportation episode
- Complete the relevant section of this form (i.e. origin or destination) along with a DMHAS Release of Information Form
- Immediately notify the livery vendor if any of the transportation details change.

INSTRUCTIONS FOR LIVERY PROVIDER:

- Call Advanced Behavioral Health, Inc (1-800-658-4472) in advance of the transportation episode to confirm eligibility.
- Sign and return the completed transportation supplement form to ABH, Inc only after the completion of the transportation episode.

Applicant Name: ________________________________ **DOB:**____________ **SS#:**____________

Requesting Provider: ______________________________ **Address:** ___________________________

Level of Care: ___________________ **Staff:** _____________________ **Phone:** ____________________
(Type of treatment) (Contact person at provider)

Origin / Pick Up Information

Date of Transport: ________________________________

Origin Agency: __________________________________Origin City: __________________________

Origin Agency Signature (on date of transport): ____

Date Signed: ___________________ Type of service / treatment:________________________

Delivery / Drop Off Information

Date of Transport: ________________________________

Destination Agency: ______________________________Destination City: ______________________

Destination Agency Signature (on date of transport): ____

Date Signed: ___________________ Type of service / treatment:________________________

Completed by Livery Vendor

Number of Miles: ________________________________(X $2.60 per mile)

Service Fee: $12.00 ____________Total Requested:___________________

Livery Vendor Signature: ____________________________________ Date Signed: ____________________

[ ] Yes [ ] No I am requesting reimbursement for this completed transportation episode

Department of Mental Health and Addiction Services (DMHAS)
Behavioral Health Recovery Program – Basic Supports

Consent to Disclosure and Re-disclosure of Confidential Information and Records

I, ________________________________ , DOB: __________ ,
(Name of Participant) (Date of Birth)

EMS# __________________________ , SS# ___________________ as a
(EMS Number) (Social Security Number)

participant in the DMHAS Behavioral Health Recovery Program, understand my treatment and support services will be coordinated through DMHAS and Advanced Behavioral Health, Inc. I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing Behavioral Health Recovery Program basic recovery support requests:

1. **The DMHAS Administrative Service Organization; and**
2. ____
   [Referring Treatment Provider/Program]
3. ____
   [Requested Service Vendor(s)]

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, BHRP Basic Recovery Supports program 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 Behavioral Health Recovery Program basic recovery support services.

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 Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and 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 completion of this application, or:

____
[Specific date, event or condition upon which this consent expires, only if different from above]

Date:_______________ ______________________________________
[Signature of Participant]

____
[Signature of parent, guardian or authorized representative where required]

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 or drug abuse patient.

Additional Client Supplement Information

Client Name: ____________________________________ DOB: ________________ Date of Transport: _____________________

Gender _____Male _____Female

Race __American Indian/Native Alaskan __Asian __Black/African American __Native Hawaiian/Other Pacific Islander __White/Caucasian

Ethnicity _____Hispanic _____Non-Hispanic

Language __English __Spanish __Italian __French __Mandarin __Japanese __Other

Religion __Protestant __Catholic __Jewish __Muslim __Buddhist __Mormon __Orthodox Christian __Hindu __Other

Pregnancy Status _____Yes _____No

Tabaco Use _____Yes ______No

Client Home Address (Please Include the City State & Zip): ____

Marital status __Never Married __Married __Separated __Divorced/Annulled __Widowed __Civil Union

Veteran status _____Yes _____No

Military Start Date _________________________

Insurance Policy Effective Date ______________________