Lehigh County Drug and Alcohol
Assessment Summary Form

Demographics:

Name:	Gender:	Race/Ethnicity:
Date of Birth:	Soc Number:	
Street Address:		
City State and Zip Code:		
County of Residence:	Marital Status:	
Number of Children under 18:	Number of Household Members:	

Other Agency Involvement:

Criminal Justice referral: ☐Yes ☐No	DUI Related: ☐Yes ☐No
Probation Officer:	
Are Consents to Release Information Signed? ☐Yes ☐No	
Is this person a Priority Population? ☐Yes ☐No	

Employment:

Name of Employer:	
Employment (EX: FT/PT):	Monthly Income:

Drug Use History:

Drug	Date Last Used	Quantity	Frequency	Route of Administration
1st Drug.				
2nd Drug.				
3rd Drug.				

Is this person on MAT? ☐Yes ☐No

If yes explain:

If no, is this person interested in MAT? ☐Yes ☐No

If yes explain:

Lehigh County Drug and Alcohol

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby consent to and authorize the Lehigh County Department of Drug and Alcohol Services to release to the
WESTMINSTER HOMES OF THE LEHIGH VALLEY
_____ _____
(Current Provider)

for the purpose of authorizing funding for the cost of treatment, the following information:

- ☐ Demographics
- ☐ Level of Care(s) Authorized for funding
- ☐ Lehigh County Fiscal Authorization Request Form
- ☐ Other (specify): _____

I understand that the above information has been disclosed from records whose confidentiality is protected by the federal confidentiality of substance abuse patient records statute, section 543 of the Public Health Service Act, 42, U.S.C. 290dd-2, and its implementing regulation, 42 C.F.R. part 2; the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations; and, the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.1010 et seq.

Federal Regulations (42 CFR Part 2) prohibits any further disclosure unless further disclosure is expressed permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I understand that I may revoke this consent at any time by notifying the Lehigh County Department of Drug and Alcohol Services, Government Service Center, S. Seventh Street, Allentown, PA 18101, verbally or in writing, except to the extent that action has been taken in reliance on my consent.

I understand that generally the Lehigh County Department of Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but that in limited circumstances I may be denied treatment if I do not sign a consent form.

I have been offered a copy of this document and have (please initial appropriate space):

_____ACCEPTED _____REFUSED

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

Expiration Date _____

Lehigh County Drug and Alcohol

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ , do hereby consent to and authorize the Lehigh County Department of Drug and Alcohol Services to release to

_____

(Additional Agencies)

for the purpose of authorizing funding for the cost of treatment, the following information:

- ☐ Demographics
- ☐ Level of Care(s) Authorized for funding
- ☐ Lehigh County Fiscal Authorization Request Form
- ☐ Other (specify): _____

I understand that the above information has been disclosed from records whose confidentiality is protected by the federal confidentiality of substance abuse patient records statute, section 543 of the Public Health Service Act, 42, U.S.C. 290dd-2, and its implementing regulation, 42 C.F.R. part 2; the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations; and, the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.1010 et seq.

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I have been offered a copy of this document and have (please initial appropriate space):

___ACCEPTED ___REFUSED

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

Expiration Date _____

DESCRIPTION OF TYPES OF INCOME

Earned Income:	Wages, salaries, fees, commissions, tips, bonuses, net business income and other earned income subject to Federal income taxation.
Interest Income:	Interest income including, but not limited to, interest received from accounts with banks, savings and loan associations, money market funds, credit unions or bonds.
Dividends:	Dividends received from corporate stock holdings or cash dividends from life insurance policies.
Benefits:	Taxable benefits, including but not limited to unemployment compensation, Social Security payments and pensions. Benefits are counted as income only if the benefit is paid on behalf of the client. Food stamps are not counted as income.
Alimony:	Includes alimony received or spousal support received prior to divorce. Does not include child support.
Other taxable income:	Includes all other income subject to Federal income taxation, e.g., rental income, lottery winnings, net capital gains, etc.

PART IV: CLIENT LIABILITY

Total # of dependents (listed in Part II): ☐

Total Monthly Gross Income (listed in Part III): ☐

		CLIENT LIABILITY DUE							
Service	Client Liab Percentage*	Individual Hour	Group Hour	Group Session	Day	Week	Urinalysis	Dosing	Other (Specify)
Outpatient					xxxxxxxx	xxxxxxxx		xxxxxxxx	
IOP						xxxxxxxx		xxxxxxxx	
Partial						xxxxxxxx		xxxxxxxx	
Halfway House	xxxxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx		xxxxxxxx	xxxxxxxx	xxxxxxxx	
Residential	xxxxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx		xxxxxxxx	xxxxxxxx	xxxxxxxx	
Methadone									
Other (specify)									

*Minimum co-pays may apply

AGREEMENT AND UNDERSTANDING:

I certify that the information concerning my dependents, insurance and income is true and complete to the best of my knowledge. I understand that I am responsible for paying the above fees on the same day of service. I understand that I am to notify this agency if there are any significant changes in my monthly income or family size within 30 days of such change. I understand that if these fees represent a financial burden, a staff person and I may fill out a REQUEST FOR LIABILITY REDUCTION OR ELIMINATION form.

A copy of this form has been offered to me and I have _____ accepted _____rejected it.

Client Signature _____ Date _____

Staff Signature/Witness _____ Date _____

SCA Signature (as applicable) _____ Date _____

Note: Client Liability determined on this day shall be valid for a period of no more than 12 months, with a re-determination to occur at the end of the 12-month period.