CAIRS *California American Indian Recovery Services*

Client Enrollment Application

Outpatient ~ Residential ~ Recovery Support ~ Transitional Housing ~ Sober Living

Please complete this application for each qualified CAIRS client. If this form is not completed and is not signed by the client, you may not bill for CAIRS services. This form must be stored in the client file, along with the assessment, case notes, and required documentation. You will need this form in order to enroll your client onto the Voucher Management System (VMS). If you have any questions, please contact the CAIRS Help Desk at 880-776-6004.

Part 1 – General Information

Date: _____ Intake Application Performed by: _____

A – Applicant Information (must provide proof of CA residency)

1. Name (First, Middle, Last) _____ Social Security # (last 4 digits only) _____ Mother's Maiden Name _____

2. Permanent Address _____ City _____ State _____ Zip Code _____

2. Mailing Address (if different) _____ City _____ State _____ Zip Code _____

3. Date of Birth (mm/dd/yyyy) _____ 4. Age _____ 5. Home Phone Number _____ 6. Cell Number _____

7. E-mail Address _____ 8. Facebook _____ 9. MySpace _____

B – Applicant's Legal Guardian Information (if applicable)

1. Name (First, Middle, Last) _____ 2. Cell Number _____ 3. Home Phone _____

4. Physical Address (if different from above) _____ City _____ State _____ Zip Code _____

5. Mailing Address (if different) _____ City _____ State _____ Zip Code _____

6. E-mail Address _____ 7. Facebook _____ 8. MySpace Page _____

C –California Residency Verification

One (1) of the following forms of written verification is on file that the applicant is a current and primary resident of the State of California:

- ___ Valid Driver's License or Identification Card
- ___ Current utility bill, school record, employment record, or housing record
- ___ Letter signed by the tribe verifying residency
- ___ Note signed by the client verifying homeless status
- ___ Other record deemed appropriate by CAIRS; specify: _____

D – AIAN Qualification Verification

Please note that the categories of "Self-declared AIAN" and "Foster Parent of an AIAN minor" no longer meet eligibility standard for receiving services through CAIRS funding. Please see CAIRS Policy "Client Eligibility and Enrollment" number c10.s1.0 for the complete description of eligibility requirements.

The applicant MUST meet one of the following American Indian/Alaska Native (AIAN) criteria to be eligible to receive services in the CAIRS program. This documentation must be stored in the client file. Check the one that applies:

___ Applicant is an enrolled member of a federally recognized tribe. Name of Tribe: _____

___ Descendent of an AIAN person; Name and relationship of ancestor: _____

Name of Tribe: _____

___ AIAN resident of California who:

___ Holds trust interests in public domain, national forest, or AIAN reservation allotments in CA, or

___ Is listed on the plans for distribution of the assets or CA descendant of such an AIAN person, or

___ Is a descendant of an AIAN person who resided in CA on June 1, 1852, is regarded as an AIAN by the community in which he/she lives, and has close socio-economic ties to their AIAN community

___ A non-AIAN minor (Ages 12 through 18) who is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an enrolled member of a federally recognized AIAN tribe:

Name of AIAN adult: _____

Relationship to minor: _____ Name of Tribe: _____

___ A non-AIAN spouse or registered domestic partner who is currently married to/living with an AIAN person. The AIAN must meet the eligibility requirements of the CAIRS program for the non-AIAN spouse or registered domestic partner to be eligible. The AIAN must certify to the relationship:
Name of AIAN spouse or domestic partner: _____

Name of Tribe: _____ Signature of AIAN: _____

___ A domestic partner (not registered) who is currently living with an AIAN person. The AIAN must meet the eligibility requirements of the CAIRS program and provide a signed note stating the non-AIAN partner has been living with the AIAN for one year or longer.

Name of AIAN spouse or domestic partner: _____

Name of Tribe: _____ Signature of AIAN: _____

___ A non-AIAN parent or step-parent that is currently living with an AIAN minor. The AIAN must meet the eligibility requirements of the CAIRS.

Name of AIAN minor: _____

Name of Tribe: _____

E – Provider Options

CAIRS is committed to offer each client a genuine, free, and independent choice among secular and spiritual providers. CAIRS guarantees each client a choice among individual providers, service agencies, and service options whenever possible to best meet the client's unique needs.

Providers must offer at least two options of treatment providers and must inform the client that they may also contact the CAIRS Help Line (888-776-6004) if the client would like to learn more about other service options and to obtain a list of alternative providers in their area.

1. CAIRS Providers offered to applicant:

CAIRS Provider Name	Services Offered (Clinical, RSS, etc)
CAIRS Provider Name	Services Offered (Clinical, RSS, etc)
CAIRS Provider Name	Services Offered (Clinical, RSS, etc)

2. Applicant choice of Providers:

CAIRS Provider Name	Services (Clinical, RSS, etc)
CAIRS Provider Name	Services (Clinical, RSS, etc)

Part 2 – Authorization for Use and Disclosure of Client Information

A – Applicant Identification

I, _____ (name of Applicant), hereby, voluntarily authorize the disclosure of information from my records.

B –Disclosure By

Information is to be disclosed by:

_____ _____
Organization Name Telephone Number

_____ _____ _____ _____
Mailing Address City State Zip Code

C –Disclosure To

The information is to be disclosed to:

California American Indian Recovery Services (CAIRS)
4400 Auburn Blvd, 2nd Floor
Sacramento, CA 95841
Phone: 916-929-9761 ~ Fax: 916-263-0207

D –Disclosure

The information to be disclosed is any information relating to substance abuse treatment or recovery support services paid for by the CAIRS Program alone or in combination with other sources. I understand this information will be used to:

- Evaluate services received
- Prepare required reports for CAIRS funding agency
- Determine CAIRS responsibility to pay for these services
- Report information required by the Substance Abuse and Mental Health Services Administration (SAMHSA) which funds the CAIRS program.
- Perform audits of providers records for their compliance with CAIRS Program requirements
- Verify client and program eligibility
- Conduct five to eight month follow-up evaluation interview

This authorization expires 12/31/14.

E –Clients' Rights to Privacy

I may refuse to sign the authorization. However, I understand that CAIRS cannot pay for services unless it has authorization from me to collect this required information. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of by submitting a request in writing to the CAIRS provider(s) that I receive services from. I may revoke this authorization at any time, but I must do so in writing and submit it to the California American Indian Recovery Services (CAIRS) Program, 4400 Auburn Blvd., 2nd Floor, Sacramento, CA 95841. My revocation will take effect on the date the revocation is received by CAIRS, except to the extent that others have acted in reliance upon this authorization. I have the right to receive copies of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by CA law and may no longer be protected by federal confidentiality law (HIPPA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Print Name of Applicant	Signature of Applicant	Date

Part 3 – Consent to Participate in Substance Abuse Treatment Studies, Evaluations, and Follow-up

A – Health Study Locator Information

Statement to Client: "We are collecting locator information that will help us reach you to participate in the six-month follow-up interview. Your locator information will only be used to contact you, will not be shared with any person or organization, and will be kept separate from your follow-up interview responses. CAIRS provides a $20 incentive to clients who participate in this six-month follow-up interview. When contacting you for the follow-up interview, we will tell other contacts that you are participating in a health study and will not make references to the CAIRS Program or any services you may have received."

B –Client Contact Information

Date: _____

1. Name (First, Middle, Last) _____ 2. Other names, nick names, maiden name, etc. _____

3. Place of Birth (City, State) _____ 4. Work Phone Number _____

5. Driver's License/State ID # _____ 6. State _____ 7. Vehicle Make _____ 8. Model _____ 9. Year _____

26. Military Branch _____ 27. Military ID # _____ 28. Years in Military Service _____

C –Applicant's Friends and Family Contact Information

Friend #1

1. Name (First, Middle, Last) _____ 2. Home Phone # _____ 2.Cell Phone # _____ 3. Work Phone # _____

4. Street Address _____ 5. City _____ 6. State _____ 7. Zip Code _____

8. E-mail Address _____ 9. Facebook _____ 10. MySpace Page _____

Friend #2

1. Name (First, Middle, Last) _____ 2. Home Phone # _____ 2.Cell Phone # _____ 3. Work Phone # _____

4. Street Address _____ 5. City _____ 6. State _____ 7. Zip Code _____

8. E-mail Address _____ 9. Facebook _____ 10. MySpace Page _____

Relative #1

1. Name (First, Middle, Last) | 2. Home Phone # | 2.Cell Phone # | 3. Work Phone #

4. Street Address | 5. City | 6. State | 7. Zip Code

8. E-mail Address | 9. Facebook | 10. MySpace Page

Relative #2

1. Name (First, Middle, Last) | 2. Home Phone # | 2.Cell Phone # | 3. Work Phone #

4. Street Address | 5. City | 6. State | 7. Zip Code

8. E-mail Address | 9. Facebook | 10. MySpace Page

D –Case Worker, Doctor, Community Clinic and Religious Institute - continued

Contact #1

1. Individual Name (First, Middle, Last) | 2. Work Phone # | 3.Cell Phone #

4. Agency Name | 5. Type of Agency

6. Street Address | 7. City | 8. State | 9. Zip Code

10. E-mail Address | 11. Facebook | 12. MySpace Page

Contact #2

1. Individual Name (First, Middle, Last) | 2. Work Phone # | 3.Cell Phone #

4. Agency Name | 5. Type of Agency

6. Street Address | 7. City | 8. State | 9. Zip Code

10. E-mail Address | 11. Facebook | 12. MySpace Page

1. Do you receive money or food stamps regularly from an agency? ___Yes ___No

If yes, name of agency: _____

When is it paid? _____ (mm/dd/yyyy) Where is the check sent? _____

Where do you cash the check? _____

Caseworker Name: _____ File #: _____

Who is your representative payee? _____ Phone: _____

Street Address	City	State	Zip Code
_____	_____	_____	_____

2. Where do you regularly hang out or meet with friends?

Place: _____ Phone: _____ Times you're there: _____

Address or intersection: _____

3. Are you on probation, parole, or have an active court case? ___ No ___Yes, please advise:

Agency: _____ ID #: _____

Probation/Parole Officer Name: _____ Phone: _____

Part 4 – Consent to Treatment and Client Rights

A –Applicant Certification

1. I,_____ (applicant name) consent to participate in alcohol or other drug abuse treatment, treatment evaluation, and follow-up. I understand that I will be interviewed by a CAIRS provider or independent evaluator about my presenting problems and the services I received through CAIRS at the time of assessment and upon discharge from the CAIRS program. I also understand that I will be contacted and interviewed five to eight months after my initial intake into CAIRS by a provider or independent evaluator regarding my progress since treatment.
2. I understand that I/we have a right to appeal any decision regarding the disposition of this application.
3. Check "a" or "b":

   ___ a. I have a current substance abuse problem
   The substance(s) I currently abuse is/are: _____

   ___ b. I am in active recovery from substance abuse
   I have been clean and sober since (date): _____
4. I have provided contact information where I believe I can be located in the future, and the names, addresses, and phone numbers of other who may be of help in locating me.
5. I understand that these persons will only be contacted concerning my whereabouts and that nothing about my treatment of my condition or the fact that I was in treatment will be disclosed to them or anyone else.
6. 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.
7. I certify that I was offered choice by the practitioner of at least two alternate CAIRS Providers, and that my choice was freely made.
8. I certify the information contained in this application is correct.
9. I understand that I will be interviewed by a CAIRS provider or independent evaluator about my issues related to substance abuse and the services I received through CAIRS at the time of assessment and upon discharge from the CAIRS program. I also understand that I will be contacted and interviewed five to eight months after my initial intake into CAIRS by a provider or independent evaluator regarding my progress since treatment. I also understand I will be paid $20 to complete the five to eight month interview.

Print Name of Applicant	Signature of Applicant	Date
Print Name of Legal Representative	Signature of Legal Representative	Date

B – Applicant's Rights

Statement to Client: "CAIRS is committed to offer you a genuine, free, and independent choice among secular and faith-based providers. The CAIRS Provider must minimally offer you two or more options of treatment or recovery support providers, and must inform you that you may also contact the CAIRS Help Desk (888-600-4777) if you would like to learn more about other service options and to obtain a list of alternate CAIRS Providers in your local area.

CAIRS program pledges to respect your rights as an individual. These are some rights that all CAIRS clients have:

- Client choice of provider
- Client autonomy
- Right to be treated respectfully
- Right to appropriate services
- Right to make a complaint
- Right to safety
- Right to non-discrimination
- Right to a supportive drug-free environment
- Treatment without regard to gender, race, national origin, color creed, political affiliation, sexual orientation, marital status, religion, ancestry, identity, age, military or veteran status, mental and physical disabilities, medical conditions, previous criminal record, or public assistance status
- Treatment in an environment that promotes dignity, respect, health, and safety
- Confidentiality of information regarding participation in the program and of all treatment records
- Discharge of self from the program at any time without physical and psychological harassment
- Protection from real or threatened corporal punishment, from physical, emotional, and sexual abuse, and from involuntary physical confinement

If you have complaints or concerns, you may contact the CAIRS Administration at 916-929-9761 or call the Compliance Hotline at 800-884-1735.