



SUPPORT4HOUSING (S4H)

Confidential Participant Information under HIPAA & 42 CFR Part 2

What We Do

S4H (a part of Support4Recovery, Inc.) provides short-term rental assistance grants in approved Sober Living Environments (SLE's), for those who are homeless and transitioning from either a Residential Treatment Program or currently enrolled in an Outpatient Program.

SOBER LIVING ASSISTANCE APPLICATION

(All items must be completed)

Participant Name: _____

Participant's Personal Phone: _____ Participant D.O.B. ___/___/___

Participant current email: _____

Gender: (select one) F M Other Unspec./Preferred not to state

Program Name and Address & Zip Code: _____

Counselor Name and Phone number: _____ Ext. _____

Counselor's current email: _____

What is your expected date of completion? _____

Name of IOP and Intake Date: _____

Name of SLE: _____ Rent \$: _____

Address and Zip Code: _____

SLE Contact Person: _____

Phone: _____

APPLICATION REQUIREMENTS:

- Submit your application at least 2 weeks prior to discharge date.
- Incomplete applications will NOT be accepted. Every line must be filled out.
- All applicants must be approved by S4R prior to moving into the SLE.

To ensure HIPAA compliance we only accept applications faxed to 925-848-2739. We are not allowed to receive emailed applications. You will be informed if you are approved.

Race/Ethnicity: (select one)

- Caucasian/Non-Hispanic
- African-American
- American Indian/Alaska Native
- Pacific Islander

Asian:

Chinese Other Asian _____

Japanese _____

Vietnamese _____

Korean

Middle Eastern

Hispanic:

Mexican Other Hispanic _____

Central American _____

South American _____

Puerto Rican

Declined to State



Participant applying for grant: On a separate piece of paper please provide details describing your recovery so far; sobriety date; challenges; progress made; your sober support system; and any relapses. Include ways you maintain your recovery and any future goals. What is your plan to obtain employment? (This may be typed or handwritten.) **Your application will be incomplete and will be rejected without this page.**

You are required to be actively seeking employment while receiving the rental assistant grant.

What are you currently doing to become financially independent? _____

Do you do any volunteer work? Where? _____ Hours per week? _____

Do you regularly attend self-help meetings, support groups, church, other? How often? _____

Are you currently on parole or probation? ****Which/How Long:** _____

*** (Please note: Being on parole or probation will not affect S4H's decision. However, it may affect which SLE you can select)*

What is your source(s) of income? _____ Amount (s)\$ _____

Other income source(s) and amounts: _____

Have you applied to any other agencies for housing assistance? When: _____

Name(s) of Agency(s) _____

In the past 12 months, have you received a rental assistant grant from Support4Recovery? *Circle one:*

YES NO Date(s): _____



HOUSING ASSISTANCE REQUIREMENTS:

I understand that I am required to meet with my S4H mentor once a month and that missed meetings **may** result in my assistance (grant) being discontinued. Initial _____

I understand that S4H requires regular alcohol and other drug testing and that a relapse **will** result in my support (grant) being discontinued. Initial _____

I have signed the attached consent form that allows my SLE to share alcohol and other drug test results with S4H. Initial _____

I understand that if I am incarcerated for any new criminal charges that my support (grant) **will** be discontinued. Initial _____

Print Name _____

Signature _____ Date: _____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____

(Participant’s name. Please print)

authorize:

(Name or general designation of alcohol/drug program permitted to make the disclosure)

To disclose information to: **SUPPORT4HOUSING (S4H is a component of Support4Recovery-S4R)**

(Name of person or organization to which the disclosure is to be made)

The following information: **INTAKE AND DISCHARGE DATES, PROGRESS IN PROGRAM,**

DRUG/ALCOHOL TEST RESULTS

(Nature AND amount of information to be exchanged, as limited as possible)

The purpose of the disclosure authorized in this consent is to:

ASSIST WITH HOUSING SUPPORT

(Purpose of the disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under 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. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 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, and that in any event this consent expires automatically as follows:

Date Which Consent Expires: *(if no date is specified, this consent expires upon discharge from the treatment program or one year from the date it was signed, whichever occurs first. If applicable, please specify event or condition upon which this consent may also expire:*

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.

I have been provided a copy of this form.

Printed Name

Signature of Participant

Date

S4H Consent to Release Information 11/2021 S4R-EIN-61-1538303

Item: TX PRG



CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____

(Participant's name. Please print)

authorize: **SUPPORT4HOUSING (S4H is a component of Support4Recovery-S4R)** _____

(Name or general designation of alcohol/drug program permitted to make the disclosure)

To disclose information to: **SHELTER INC**

(Name of person or organization to which the disclosure is to be made)

The following information: **INTAKE AND DISCHARGE DATES, PROGRESS IN PROGRAM,** _____

DRUG/ALCOHOL TEST RESULTS

(Nature AND amount of information to be exchanged, as limited as possible)

The purpose of the disclosure authorized in this consent is to:

ASSIST WITH HOUSING SUPPORT

(Purpose of the disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under 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. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 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, and that in any event this consent expires automatically as follows:

Date Which Consent Expires: *(if no date is specified, this consent expires upon discharge from the treatment program or one year from the date it was signed, whichever occurs first. If applicable, please specify event or condition upon which this consent may also expire:*

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.

I have been provided a copy of this form.

Printed Name

Signature of Participant

Date

S4H Consent to Release Information 11/2021 S4R-EIN-61-1538303

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42 CFR Part 2 and HIPAA

Remember: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting re-disclosure.

I, _____
(Participant's name. Please print.)

authorize: _____
(Name of Sober Living Environment. Please print.)

to disclose: **on-going AOD test results & adherence to House Rules**

to: **Support4Recovery, Inc/Support4Housing**

for the purpose of: **ensuring the Participant is able to remain clean and sober during their grant period.**

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 written consent unless otherwise provided by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

Date Which Consent Expires: *(if no date is specified this consent expires upon discharge from the Sober Living Environment (SLE) or one year from the date it was signed, whichever occurs first.)* If applicable, please specify event or condition upon which this consent may also expire: _____

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 disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____
Signature of Participant

Signature of person signing form if not Participant

Describe authority to sign on behalf of Participant

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. Updated March 23, 2017 by Legal Action Center

S4R/S4H Consent to Release of Information
S4R EIN: 61-1538303 Item: SLE



Do you have children: YES - if yes, list below: NO

GENDER IDENTIFIED	AGE

Do you: (Check all that apply)

- Have custody of your children
- Have parental rights: Yes or No If No:
 - Parental rights been terminated
- Have an open adoption
- Other (Please explain) _____

CALWORKS		
Are you receiving CalWorks?	YES	NO
If No: Are you eligible for CalWorks:	YES	NO

Below is for Office use only

Date Submitted _____

Date Reviewed: _____

Date Approved: _____

Forms Received:
Release of alcohol and other drug testing results –SLE []
Treatment counselor recommendation []
Treatment program/facility Release of Information []
S4R Release of Information []

Date Not Approved and reason: _____

Support4Recovery, Inc. is a 501©(3) Non-Profit Corporation EIN: 61-1538303

Item: Application
10/11/2021

