Heartland
Regional Alcohol
& Drug Assessment Center

P.O. Box 1063 • Mission, Kansas • 66222-0063
Phone: 913-789-0951 or 1-800-281-0029 • Fax: 913-789-0954

Welcome to Heartland Regional Alcohol and Drug Assessment Center (Heartland RADAC),

I am honored that you have chosen this agency to assist you in evaluating the impact alcohol and/or drug use is having on your life. The clinical staff are all credentialed and/or licensed through the State of Kansas, which can assure you that they are well trained and able to assess your clinical needs. I trust you will find the staff professional and dedicated to helping you achieve your goals.

The mission statement of Heartland RADAC states that we are committed to serving individuals, families and communities affected by the impact of substance abuse. We strive to accomplish this through several services: objective alcohol and drug assessments, case management, care coordination, and education. By using nationally recognized tools, and best practices, we feel confident that you will receive quality services.

All services at Heartland RADAC begin with an alcohol and drug assessment to determine if you will benefit from treatment due to alcohol and/or drug use. The results of our assessment are strictly confidential. However, if you consent, written documentation of the assessment results and recommended course of action can be provided to any person that you identify. Just let us know how we can assist you. If treatment is recommended, our staff will assist you in identifying an educational group, community support group, or formalized treatment program that best matches your individual needs. In some instances, additional services and support can be provided through case management and care coordination.

A substance use disorder is recognized as a medical disease that impacts many individuals and their families. This illness crosses all gender, racial and economic lines...and it is possible to manage and recover.

Heartland RADAC staff is dedicated to providing you with the best opportunity to address substance abuse issues. If you ever have questions concerning your access to treatment, please contact us at 913-789-0951.

Respectfully,

Jason B. Hess

Jason Hess, LCAC
Executive Director
Heartland Regional Alcohol/Drug Assessment Center

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COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURE

Complaints regarding services provided by the staff of Heartland RADAC may be addressed in the following manner.

1. Contact Sara Jackson, Clinical Director at (913) 789-7152.

If the complaint is not resolved, proceed to the next level.

2. Contact Executive Director in writing and mail to at Heartland RADAC's main office.

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Attn: Jason Hess
P.O. Box 1063
Mission, KS 66222-0063

If written grievance relates to a negative concurrent review and/or placement, the Executive Director will:

1. Collect and review all clinical information related to the grievance.
2. Contact the party filing the grievance in writing within 5 working days with a determination.
3. If the dispute cannot be resolved, the parties may hire an impartial Independent Reviewer to review all clinical information and render an opinion. All costs associated with the Independent Reviewer will be shared equally between the Heartland Regional Alcohol and Drug Assessment Center and the party filing the grievance. **TIME FRAME: 10 working days.**
4. If the opinion of the Independent Review is not accepted by either party, an appeal process may be requested.
5. If the dispute cannot be resolved, the grievance will be referred to:

The State of Kansas Department for Aging and Disability Services
Behavioral Health Services
503 S. Kansas
Topeka, Kansas 66603
(785) 296-6807

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CONFIDENTIALITY OF

ALCOHOL AND DRUG ABUSE CLIENT RECORDS

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by this agency. Generally, the agency may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser **UNLESS:**

1. The client consents in writing; OR
2. The disclosure is allowed by a court order; OR
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
4. The client commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district or to KDADS/Behavioral Health Services.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C.290add-3 and 42 290ee-3 for Federal laws and CFR part 2 for Federal Regulations.)

Heartland RADAC is in compliance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA). This client notice form describes how we may use and disclose your protected Health Information (PHI).

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CLIENT RIGHTS AND RESPONSIBILITES

Heartland Regional Alcohol & Drug Assessment Center shall support and protect the fundamental human, civil, constitutional, and statutory rights of each client and family member. Clients will be given a copy of their rights at the time of the assessment or as soon thereafter as is practical. Each client is entitled to the following rights and privileges without limitations:

1. To be treated with dignity and respect,
2. To be free from abuse; neglect; exploitation; restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation,
3. To a safe, sanitary, and humane living environment that provides privacy and promotes dignity,
4. To receive treatment services free of discrimination based on the client's race, religion, ethnic origin, age, disabling or a medical condition, and ability to pay for the services,
5. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without consent, except for photographing for identification and administrative purposes, as provided by R03-602, or video recordings used for security purposes that are maintained only on a temporary basis,
6. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights,
7. To confidential, uncensored, private communication that includes letters, telephone calls, and personal visits with an attorney, personal physician, clergy, KDADS/Behavioral Health Services staff, or other individuals unless restriction of such communication is clinically indicated and is documented in the client record,
8. To practice individual religious beliefs including the opportunity for religious worship and fellowship as outlined in program policy,
9. To be free from coercion in engaging in or refraining from individual religious or spiritual activity, practice, or belief,
10. To receive an individualized treatment plan that includes the following:

a. Client participation in the development of the plan,
b. Periodic review and revision of the client's written treatment plan,

11. To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health,
12. To receive a referral to another program if the licensee is unable to provide a treatment service that the client requests or that is indicated in the client's assessment or treatment plan,
13. To have the client's information and records kept confidential and released according to R03-602,
14. To be treated in the least restrictive environment consistent with the client's clinical condition and legal status,
15. To consent in writing, refuse to consent, or withdraw written consent to participate in research, experimentation, or a clinical trial that is not a professionally recognized treatment without affecting the services available to the client,
16. To exercise the licensee's grievance procedures,
17. To receive a response to a grievance in a timely and impartial manner,
18. To be free from retaliation for submitting a grievance to a licensee, KDADS/Behavioral Health Services.
19. To receive one's own information regarding medical and psychiatric conditions, prescribed medications including the risks, benefits, and side effects, whether medication compliance is a condition of treatment, and discharge plans for medications,
20. To obtain a copy of the client's clinical record at the client's own expense,
21. To be informed at the time of admission and before receiving treatment services, except for a treatment service provided to a client experiencing a crisis situation, of the
    a. Fees the client is required to pay, and
    b. Refund policies and procedures, and
22. To receive treatment recommendations and referrals, if applicable, when the client is to be discharged or transferred.

CLIENT RESPONSIBILITES

1. Client agrees to present accurate information regarding financial and personal history.

2. Client will make every effort to complete referral and keep scheduled appointments.

3. Clients will conduct themselves in an appropriate manner at all appointments.

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Infectious Diseases

What is an infectious disease?

Infectious diseases are disorders caused by organisms — such as bacteria, viruses, fungi or parasites. Many microorganisms colonize in and on our bodies. Signs and symptoms of infectious diseases vary, but often include fever and chills. Mild complaints may respond to home remedies, while some life-threatening infections may require hospitalization and intravenous antibiotics.

How do you contract infectious diseases?

Infectious diseases can be spread in a variety of ways. Some diseases can be spread through spores ejected into the air by an infected persons cough in close spaces, but most of these diseases are spread through direct contact or sexual contact with an infected person.

High risk behaviors:

Participating in high risk behaviors is a leading cause of infectious disease cases. To prevent the spread of disease, **avoid** these behaviors.

- Intravenous drug use
- Sharing needles
- Sex with (or as) a prostitute
- Anal Sex
- Multiple Sex partners
- Sex with someone of the same gender.

Tuberculosis

"TB" is short for a disease called tuberculosis. Tiny germs that can float in the air spread TB. The TB germs may spray into the air if a person with TB disease of the lungs or throat coughs, shouts, or sneezes. Anyone nearby can breathe TB germs into their lungs. You cannot get TB from someone's clothes, drinking glass, handshake, or toilet.

TB Symptoms Include:

- Cough
- Unexplained weight loss
- Fatigue
- Fever
- Night sweats
- Chills
- Loss of appetite

For more information about tuberculosis or any lung disease, contact American Lung Association at 1-800-586-4872 or visit the website at www.kslung.org.

HIV/AIDS

How HIV is spread?

HIV is spread by having vaginal, anal or oral sex with an infected person, by sharing needles or syringes and during pregnancy, birth or breast-feeding from an infected mother to her baby. Body fluids of an infected person that spread HIV are semen, blood, vaginal fluid, and breast milk.

Stopping the spread of HIV/AIDS

The most effective way to stop the spread of HIV is through avoiding high risk behaviors, using clean needles (if individual is IV drug user), and wearing a condom the correct way **EVERY SINGLE TIME** during sexual intercourse.

National AIDS Hotline (CDC): 1-800-342-AIDS or 1-800-342-SIDA

Hepatitis

Hepatitis is a disease that is characterized by the inflammation of the liver. There are 5 different types of Hepatitis. Hepatitis A,B,C,D, and E. The cause of these diseases can vary but high risk behaviors and substance abuse is a leading cause of contracting a Hepatitis virus.

Hepatitis Symptoms:

In almost all cases of Hepatitis, abdominal pain, weakness, loss of appetite, jaundice, aching joints, headaches, fevers, nausea, dark-colored urine, enlarged liver, digestion problems are present. If you think you, or someone you know is infected, contact a physician immediately for testing.

Sexually Transmitted Infections (STI's)

STI's are diseases such as Herpes, Chlamydia, Genital Warts, HPV (Human Papillomavirus), Gonorrhea, Syphilis etc…

There are many varying symptoms of STI's; these diseases are spread through **unprotected** anal, vaginal, and oral sex with an infected individual. The easiest way to avoid contracting an STI is through safe sexual habits such as:

- ✓ **Abstinence:** The most reliable way to avoid infection is to not have sex (i.e., anal, vaginal or oral).
- ✓ **Reduced number of sexual partners:** Reducing your number of sex partners can decrease your risk for STI's. It is still important that you and your partner get tested, and that you share your test results with one another.
- ✓ **Mutual monogamy:** Mutual monogamy means that you agree to be sexually active with only one person, who has agreed to be sexually active only with you. Being in a long-term, mutually monogamous relationship with an uninfected partner is one of the most reliable ways to avoid STI's. But you must both be certain you are not infected with STI's. It is important to have an open and honest conversation with your partner.
- ✓ **Protection (Condoms):** Correct and consistent use of the latex condom is highly effective in reducing STI transmission. Use a condom **every time** you have anal, vaginal, or oral sex.

- ❖ If you are at risk of any of these conditions, contact a physician immediately for testing.
- ❖ For more information on any of these conditions, and other infectious diseases contact the Center for Disease Control and Prevention at www.cdc.gov OR call 1-800-232-4636 (800-CDC-INFO). This is an integrated CDC hotline service. This line will accommodate English and Spanish.

HEARTLAND REGIONAL
ALCOHOL & DRUG ASSESSMENT CENTER

ELIGIBILITY & SCHEDULING

Eligibility & Fee Schedule Guidelines

It is the policy of Heartland RADAC to offer an assessment and/or treatment to any individual who requests our services. If the individual is willing to provide proof of personal and demographic information regarding residency, income and household size, we will be able to determine whether they fall within eligibility guidelines to enable a portion of the fee to be paid by Behavioral Health Services (BHS) /AAPS Funds, Medicaid funds or other third party payers on a sliding scale.

Behavioral Health Services (BHS) /AAPS Funded, Federal Block Grant funds are available for clients who are documented residents of Kansas **and** who have documented income at, or below, 200% of the Federal Poverty Guidelines (FPG). Clients must meet **both** residency requirements and income eligibility before they will be considered eligible for BHS/AAPS funds.

To determine eligibility for BHS /AAPS funding, clients are required to submit documentation to Heartland RADAC, which confirms that their income is within Federal Poverty Guidelines and affirms Kansas Residency. If the client is unable or unwilling to provide the documentation, they will be charged the fee for the assessment ice, due at the time of the assessment or before.

Residency Determination

As evidence of Residency, each client will be asked to provide one of the following:

- Social Security Card
- Current Kansas Driver's License
- Certificate of U.S. Citizenship
- Certificate of Naturalization
- Birth Certificate
- INS Employment Authorization, or
- Any document under list A of the Federal I-9 form (passport, permanent resident card, alien registration card)

AND

- Kansas Driver's License
- KS Native American Tribal Document
- Kansas Medical Card
- Kansas Identification Card
- Apartment or house rental receipt in the client's name with a Kansas address
- Utility Bill in client's name and with a Kansas address.
- Signed statement of a family member upon which the client is dependent upon for shelter.
- Signed letter on agency letterhead from a criminal justice staff person or probation officer
- Signed letter on agency letterhead from a social services staff person or similar professional (homeless shelter, therapist, KDCFS case worker, social worker, etc) affirming the person is a resident of KS.
- Individuals incarcerated in Kansas need to provide documentation of scheduled release within the next 60 days.

Income Determination

Compliance with Federal Poverty Guidelines (see most recent FPG at http://aspe.hhs.gov/poverty/) shall be documented through financial documents:

- Pay Stubs
- Income Tax Returns
- Letter of unemployment benefits
- Annual benefits letter
- Bank statements
- Signed statement of a family member upon which the client is dependent upon for food or shelter
- Signed letter on agency letterhead from a criminal justice staff person or probation officer
- Signed letter on agency letterhead from a social services staff person or similar professional (homeless shelter, therapist, KDCFS case worker, social worker, etc)

Income is described as earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, etc.

Noncash benefits such as food stamps and housing subsidies do not count as income.

Income will be determined by the following guidelines at the time of assessment:

a. Income will be calculated based on earnings over the 90 day period (three months) immediately preceding date services are requested.

b. A single person age 18 or older will be considered a household of one, regardless of living arrangements, and only his/her income will be counted.

c. The income of a person who considers him or herself to be married (legally, common-law, or represents themselves as married) will be based on the combined income of the client and the spouse, and the household size will be two plus any dependent children living in the home.

d. The income of a client who is a single parent will be based on the client's income, and the household size will be one plus any dependent children living in the home.

e. A client under 18 years of age living with both legal parents will have his/her income determined based on his/her parents' combined income, and the household size will be three (both legal parents + client) plus any additional dependent children living in the home in accordance with "c" above.

f. A client under 18 years of age living with a single (legal) parent will have his/her income based on his/her single parent's income and the household size will be two (client + parent) plus any additional dependent children living in the home in accordance with "d" above.

   - *This standard can apply to an adolescent client whose bio-parent is married, but the step-parent has not legally adopted the client. Step-parents would not be counted in income or number in household, unless the child has been legally adopted.*

g. JJA Clients in State custody, and living at home, will have his/her income determined based on his/her parent(s) income and the household size will be determined based on household size, including parents and any additional dependent children in the home as in "e" or "f" above.

Definition of dependent child: 17 and younger, unmarried, received more than half of his or her support from the parent with whom they reside, must reside with the parent for more than 6 months of the year and meet the residency requirements.

Service Fee Schedule 2020

	Medicaid	Below 100% FPG with KS Residency Documents	Between 100% & 200% FPG with KS Residency Documents	Below 100% FPG without KS Residency Documents	Between 100% & 200% FPG without KS Residency Documents	Above 200% FPG	1st / 2nd DUI Pre-Sentence Evaluation	3rd & Subsequent DUI w/ Journal Entry
Funding	**Medicaid**	**AAPS/BHS**	**AAPS/BHS + Sliding Fee**	**Self-Pay Non-AAPS**	**Self-Pay Non-AAPS**	**Self-Pay Non-AAPS**	**Self-Pay Non-AAPS**	**3rd/4th DUI**
Assessment	$0.00	$0.00	$100.00	$100.00	$200.00	$200.00	$200.00	$0.00
Individual Therapy	$0.00	$0.00	$0.00	$100.00	$100.00	$100.00	See Previous	N/A
Group Therapy	$0.00	$0.00	$0.00	$40.00	$40.00	$40.00	See Previous	N/A

***In the event that a fee has been collected in error, the money will be refunded. The refund will be made to the person or organization (payer) who paid the fee. The fee will be returned to the payer by Cashier's Check within 14 days of receiving request.

100% of Federal Poverty Guidelines 2020

Number In Family	1	2	3	4	5	6	7	8	Each Additional Person
.ual Income	$12,760	$17,240	$21,720	$26,200	$30,680	$35,160	$39,640	$44,120	$4,420
Monthly Income	$982	$1,326	$1,670	$2,015	$2,360	$2,704	$3,049	$3,393	$368
Hourly Income	$7	$9	$11	$13	$16	$18	$20	$23	$2

200% of Federal Poverty Guidelines 2020

Number In Family	1	2	3	4	5	6	7	8	Each Additional Person
Annual Income	$25,520	$34,480	$43,330	$52,400	$61,360	$70,320	$79,280	$88,240	$8,840
Monthly Income	$1963	$2,652	$3,333	$4,030	$4720	$5,409	$6,098	$6787	$737
Hourly Income	$13	$18	$22	$27	$31	$36	$41	$45	$5

*Gross Income

Updated 7/2012, 12/2012, 07/2013, 07/2014, 11/2015, 7/2017, 7/2018, 7/2019, 7/2020

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Name: _____ Date: _____

CAGE-AID Questionnaire

Questions can be asked verbally all at once or integrated into the clinical interview. Please check the space next to Yes or No depending on the client's answer.

Yes _____	No _____	Have you ever felt you should cut down on your drinking or drug use?
Yes _____	No _____	Have people annoyed you by criticizing your drinking or drug use?
Yes _____	No _____	Have you ever felt bad or guilty about your drinking or drug use?
Yes _____	No _____	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Scoring:
Item responses on the CAGE-AID are scored 0 (No) or 1(Yes), with a higher score an indication of alcohol or drug problems. A total score of 2 or greater is considered clinically significant.

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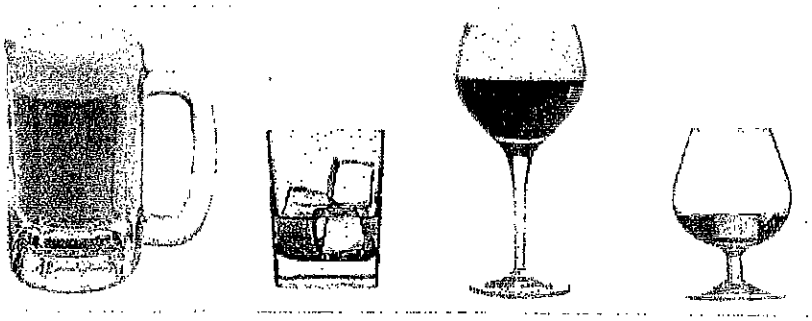
AUDIT Alcohol Questionnaire

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking. The following questions are about your drinking habits.

To help you answer correctly, we've listed the serving size of one drink below.

Standard serving of one drink:



12 ounces of beer or wine cooler

1.5 ounces of 80 proof liquor

5 ounces of wine

4 ounces of brandy, liqueur or aperitif

Rating your score:

0-7: You're at low risk for problems caused by drinking alcohol.

8-15: You could be at risk for problems caused by drinking alcohol. Making changes in your drinking habits can help lower your risk.

Above 16: Scores above 16 could mean drinking alcohol is causing problems in your life.

Talk to your health care provider about these questions and your score. He or she will be able to work with you to help you cut down or stop drinking, and discuss any concerns or questions you may have.

Circle your answers. Then find your score in the top row above your answer. At the end, total your scores and look at the back of this sheet to rate your drinking habits

Questions	0	1	2	3	4	Your score
1. How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

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DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, M5S 2S1.

DAST – 20 Scoring

Score 1 point for each question answered "yes" except for Questions 4 and 5, for which a "no" receives 1 point.

SCORE	SEVERITY	INTERVENTION Recommended
0	N/A	N/A
1-5	Low	Brief Intervention
6-10	Immediate (likely meets DSM criteria)	Outpatient (intensive)
11-15	Substantial	Intensive
16-20	Severe	Intensive

These questions refer to the past 12 months.

Circle your response

1. Have you used drugs other than those required for medical reasons?	Yes No
2. Have you abused prescription drugs?	Yes No
3. Do you abuse more than one drug at a time?	Yes No
4. Can you get through the week without using drugs?	Yes No
5. Are you always able to stop using drugs when you want to?	Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes No
7. Do you ever feel bad or guilty about your drug use?	Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes No
10. Have you lost friends because of your use of drugs?	Yes No
11. Have you neglected your family because of your use of drugs?	Yes No
12. Have you been in trouble at work because of drug abuse?	Yes No
13. Have you lost a job because of drug abuse?	Yes No
14. Have you gotten into fights when under the influence of drugs?	Yes No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes No
16. Have you been arrested for possession of illegal drugs?	Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you topped taking drugs?	Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, ect.?)	Yes No
19. Have you gone to anyone for help for a drug problem?	Yes No
20. Have you been involved in a treatment program specifically related to drug use?	Yes No

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Name: _____ DOB: _____

CLIENT VERIFICATION

My signature below verifies that:

1. I have received the policy on Confidentiality of Alcohol & Drug Abuse Client Records.
2. I have received a copy of the Complaint, Grievance & Appeal Procedure.
3. I have received a copy of the Client Rights & Responsibilities.
4. I have received a copy of the Eligibility & Service Fee Schedule pertaining to services provided by Heartland RADAC.
5. I have received a copy of the Infectious Disease handout.

I have had the all the above listed information explained to me by a member of the Heartland RADAC staff.

I hereby give my consent to receive services from Heartland RADAC staff.

_____

Client Signature Date

_____

Witness Signature Date

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Name of Client – Please Print _____ Date of Birth _____

uthorize and request Heartland Regional Alcohol & Drug Assessment Center to communicate with the following individuals, providers, id/or agencies to exchange (send and receive) through disclosure and/or re-disclosure, information needed to coordinate and assist in ordinating my care, treatment and services.

Individual / Provider / Agency Name

Designee of Substance Abuse Center of Kansas (SACK); Wichita, KS; Phone 1-316-267-3825

Designee of Beacon Health Options/Value Options of Kansas; 100 SE 9th Street, Suite 501,Topeka, KS 66612; Phone: 1-866-645-8216

Designee of Kansas Department for Aging & Disability Services (KDADS) Behavioral Health Services – AAPS; 503 S. Kansas; Topeka, KS 66603

Cenpatico/Sunflower Health Plan 8325 Lenexa Drive, Overland Park, KS 66214

Cenpatico/Sunflower State Health Plan, Attn: Referral Department, 504 Lavaca, Suite 850, Austin, TX Phone: 1-512-406-7200; Fax: 1-866-694-3649

United Healthcare/Optum, 10895 Grandview Dr. Bldg 24, Suite #200, Overland Park, KS 66211; Phone: 1-855-802-7095; Fax: 1-855-657-3526

Aetna Better Health of Kansas, Attn: Behavioral Health/SUD, 9401 Indian Creek Parkway, Suite 1300, Overland Park, KS 66210; Phone: 1-855-221-5656; Fax: 1-855-225-4102

y initialing, I am allowing communication with the entities noted above.

_____ Alcohol or Substance Use Information and/or Records **(CLIENT INITIALS ARE REQUIRED)**

To Include: • Clinical Treatment Plans / Notes • Authorizations • Denials / Grievances / Appeals • Claims Info / EOB's

Other: _____, _____, _____

understand that the information and records disclosed and/or re-disclosed pursuant to this consent are protected under 42 CFR Part 2 - onfidentiality of Substance Use Disorder Patient Records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ealth Information Technology for Economic & Clinical Health (HITECH) and 45 CFR parts 160 and 164, and State Confidentiality ws & regulations. This information cannot be released without my consent unless otherwise provided for by the regulations.

his authorization shall be in force and effect for one year or until I revoke it, in the manner described below or until **nsert expiration date or event)** _____ (whichever is shorter).

- I may revoke this consent at any time. But if revoked, the revocation will not affect the disclosure of any information that has already been disclosed / re-disclosed.
- As I authorize the release of alcohol or substance use information to a healthcare organization that is not my treating provider, I have the right, for the next two years, to request a list of entities to which my information has been disclosed, by contacting the organization directly and requesting that information in writing.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, as permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- Upon request, I will be provided a copy of this authorization.

_____ / _____

Signature of Client Date

_____ / _____ _____

Signature of Legally Authorized Representative * Date Relationship to Client

If signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you authority. xamples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient.

Heartland
Regional Alcohol
& Drug Assessment Center
P.O. Box 1063 • Mission, Kansas • 66222-0063 • Phone: 913-789-0951 or 1-800-281-0029 • Fax: 913-789-0954

_____ _____

Name of Client – Please Print Date of Birth

authorize and request Heartland Regional Alcohol & Drug Assessment Center to communicate with the following individuals, oviders, and/or agencies to exchange (send and receive) through disclosure and/or re-disclosure, information needed to coordinate id assist in coordinating my care, treatment and services.

Individual / Provider / Provider or Agency Name / City / State

_____

_____

_____

_____

_____

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_____ / _____

Signature of Client Date

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Signature of Legally Authorized Representative * Date Relationship to Client

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& Drug Assessment Center
P.O. Box 1063 • Mission, Kansas • 66222-0063 • Phone: 913-789-0951 or 1-800-281-0029 • Fax: 913-789-0954

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Name of Client – Please Print Date of Birth

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Individual / Provider / Provider or Agency Name / City / State

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To Include: • Clinical Treatment Plans / Notes • Authorizations • Denials / Grievances / Appeals • Claims Info / EOB's

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_____ / _____
Signature of Client Date

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Signature of Legally Authorized Representative * Date Relationship to Client

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Heartland
Regional Alcohol
& Drug Assessment Center

Authorization for Assignment of Benefits

Client's Name: _____ Date of Birth: _____

The undersigned hereby authorizes and requests **Heartland Regional Alcohol/Drug Assessment Center, P.O. Box 1063, Shawnee, KS, Phone: 913-789-0951, Fax: 913-789-0954.**

☒ To Release to ☒ Obtain from

x The Designee of Beacon Health Options / Value Options of Kansas
x The Designee of Aetna Better Health of Kansas
x The Designee of Sunflower State Health Plan
x The Designee of United Healthcare Community Plan of Kansas
__ The Designee of : _____
(Other Third Party Payer)

The following information:

☒ Assessment Results
☒ Kansas Client Placement Criteria Results
☒ Consultations
☒ Progress Notes
☒ Permission to file Appeal &/or Grievance if services are denied
☒ Transitional Plan
☒ Discharge Information & Summary
☒ Laboratory Reports
☒ Complete Records
☐ Other: _____

The above information is released for the purpose of processing payment of medical services thru insurance carriers, prepaid medical plans, or governmental agencies. I understand that my records (including psychiatric, alcohol abuse or drug abuse information) may be protected by Federal Regulations. 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, and that in any event this consent automatically expires one year after the date entered below (date of signature).

Executed this (day) _____ of (month) _____, (year) 20____

_____
Client Signature Date

_____
Signature of Parent, Guardian or Authorized Representative Date Nature of Relationship

_____
Signature of Witness Date

Prohibition on re-disclosure: 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 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 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.