

HACC, Inc. C.A.R.E. Assessment Request

**Please send completed forms to:
FAX 310-831-0004**

CLIENT INFORMATION

Client ID# _____

Name _____

Street Address _____

City _____ Zip Code _____

Phone _____

D.O.B _____

SSN _____

Male

Female

Transgender

Ethnicity _____

Veteran

Referral Source _____

Case Manager _____

Date of Assessment _____



California Access to Recovery Effort

(CARE 3)

Revised September 2010

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I _____ authorize HACC., Inc.
(Client name) (Provider name)

to disclose to the California Department of Alcohol and Drug Programs (ADP), MAXIMUS (ADP's voucher services contractor), and the California State Controller's Office (SCO), information regarding my enrollment and services provided in the CARE voucher program.

The purpose of the disclosure authorized herein is to verify my eligibility and participation in the CARE voucher program and to pay the program for services provided.

I understand that my records are protected under the federal confidentiality regulations (42 Code of Federal Regulations, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the 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 six months after I discontinue all CARE services.

I have been provided a copy of this form.

Client Signature: _____ Date: _____

Date: _____
Parent, guardian or authorized representative signature (if required)

Program Name: HACC, Inc.

Program Address: 599 W. 9th Street San Pedro, CA 90731

CARE Provider # 100537

